Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					.,,	Certificate of	Death	R	eg. No.	14 02001
	Dharinin		. Decedent's Name (First, Middle, Last)	10	110			2. Dete of Deet Month		3. Time of Death
	Physicia /Medica	3Î _	Miriam +	Le:	SUIC			Fan	15	04 10 mm
The state of the s	Examine	r	e Facility Name (If not institution, give st	reet end number)	1560		4b. City, Town, or Loc	ation of Death	4c. County of	Deeth I A
			Sociel Security Number 6. Sex	7. Age	(In yrs. last birt	hdav) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1-00/	Birthplace (Stete or Foreign
	Funeral Director	- 1		M 2⊠F		rs. Months Days	Hours Min.	8. Date of Birth (Month, Day, March 2	9, 1917	New York
O	p ,	_ h	Usuel Residence of Decedent Oa. Stete 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	show		Montgomer	v	Gaither					1 ☐ Yes 2 ☑ No
	vith the Maryle or 28s-f sho be notified at	<u> </u>	Oe. Street end Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
	h with		38 Russell Avenue			2087	77		United S	tates
	deat deat	e l	1. Marital Status	2. Was Decedent E Armed Forces?	ever in U,S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)		American Indien, White, etc.
Baltimore, Maryland 21215-0020	within 72 hours after death with the Maryland ane. than "natural, or flems 23a or 28a-f show he Madical Examiner must be notified at	Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo	1□Yes 2⊠ No			Specify:	White
5-0	n 72 ho natur	ete	15. Decedent's Educe (Specify only highest grede	etion completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working	ng .	16b. Kind of Busin	
121	within	Ē	Elementery/Secondary (0-12)	College (1-4or 5	+) For	reign Market blic Relati	ing and		rord Mot	or Company
d 2	Hygie Hygie	ဒ္ဓ -	7. Father's Neme (First, Middle, Last)	<u> </u>	, PL	ibile Relati	18. Mother's Name	(First, Middle, M	Maiden Surname)	
/lan	Ald be Alental	90	Winston Paul				Miriam C	. Upper	cu	
lan	1 and 2 should be filed within Haalth and Mental Hygene. em 27 ia marked other than other traumatic event, fre. Mercenter than the free free free free free free free fr		19a. Informant's Name/Relationship (Type	e, Print)	19b.	Mailing Address (Street				ate, Zip Code)
₹.	and and markh m 27 i	- 1	Buth U. Paul/ Sister	r		Russell Av	enue, Gai		rg, Mary	
ore	or of		0a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	cemeter Mont	y, crematory or other pla 20me rv	ce) Ja	nuary	Bethesd	a.
草	Demit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, in Marce.	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi → Loef see	NA	Cremat	orium. Inc.		,2004 ert A. 1	Mary1	and Funeral Home/
Ba	permi Depar Impor any Ir) XII .	11/	00600	Bethesda-C	Chevy Chas	e, Inc.	7557 Wi	sconsin Avenue
		+	23a. Pert1. Enter the disease, or complications, of heart failure. List only one		the death. Do r	ot enter the mode of dying	a, Marylan ng, such as cardiac o	r respiratory arm	-3301 est,	Approximate Interval Between
1	Physician		snock, or mearthandre. List only one	cause on eech lin	e.	1	i i			Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Cer	ebella	ar hen	morhad	10		days
		-	esuning in dealing		Due to (or as e	onsequence of):	()		1
	d ansit	Medical Examiner	Sequentially list conditions		Due to (or es e o	onsequence of):				1
ó	t be executed sician and bunal-transit	LX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury							+ 40
68760,	The law requires that the death certificeta be executed at has been signed by the ettending physician and page 2 should be detached for use es the burial-transi	g	c that initieted events resulting in death) Last	ı	Due to (or as e c	onsequence of):				
9 ×			d							
B0)	eath ce ettendii I for use	Clan					- In Donald	ook Dida	hann una annte	ibute to the cause of death?
0	es that the death ce igned by the ettend be detached for us	l ys	Part II. Other significant conditiona contr	ibuting to death bu	it not resulting in	the underlying cause gr	ven in Part I.			Probably 4 Unknown
S, D	gned to	2								
ord	v require been si should	9						24a. Was a perform		24b. Were autopsy findings available prior to completion of cause
ec	has be								/	of death?
a F	iclan: The la	3						†U¥		1 Yes 2 No
Z.	Attending Physician: T ir death. ector: Atter this certifical by the funeral director, p	ng ng	25. Was case referred to medical examiner?	spital: 1 Inpatie	nt 2□ER/Ou	tpatient 3 DOA Oth	26. Place of Death	the state of the state of	ence 6 ⊡Other	(Specify)
0	Physical distriction	=	27. Manyer of Death	28a. Date of Injur (Month, Day					ow injury occurred	
<u>io</u>	anding lath.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mornin, Day	1647)		Yes 2□No			
Division of Vital Records,	or Att		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Inju- building, etc	iry - At home, fa . <i>(Specify)</i>	rm, street, factory, office	2	8f. Location (St City or Town		or Rural Route Number,
	Hospital of Puncture a Funeral Distaly fillad i	3	29a. Certifier 1 Certifying Physic	ien: To the hest o	f my knowledge	death occurred et the ti	me date end place a	nd due to the ca	ause(s) and man	ner es stated
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completall filled in by the f	Medical Certification: 10 be Completed by Physician	(Check only one)	er: On the basis of and manner sta	examinetion end	Vor investigation, in my	opinion, death occurre	ed et the time, d	ate and place, an	d due to the cause(s)
	within 2 To the comple	Σ	29b. Signature and title of certifier	71	-	29c. Licens	se number	2	9d. Date signed ((Month, Dey, Yeer)
	10		1/2th/	John	5	0.	20148		RIEDUR (13, 2009
	1		30. Neme and eddress of person who corn	h	eeth (Item 23e) (Type, Print)	e Gaith	ersburg	m -1	
STATE OF	State	e	31. Dete filed (Month, Dey, Year)	32. Registre	or's Signature	1. 1	C, Oakir	2	110	
200 A ST	Registra	-6	JAN 1 6 2004	Sene	va /	I spark				

			1 - For State Registrar	State of M	arylan		artment c			and M		giene 200	ll.	025	02
	Physical at	J.	Decedent's Name (First, Middle	Last)							2. Date of Dea Month	Dav Y	ear	3. Time of I	Death
).	Physici /Medio Examir	al	Phyllis R. Lib 4a. Fecility Name (If not institution,				4b. City, Tov	wn, or L	ocation o		January			5:00	P M
1	L-Adiiiii		Shady Grove Adv	entist Hosp	ital		Rocky	i116	e			Montgo	merv		
	Funeral Director		5. Social Security Number 579–60–4879			last birthday) Yrs.	If Under 1 Y	'ear	If Under 2 Hours	Min.	8. Date of Birth (Month, Day June 6.	, Yeer)			Foreign
	ס		Usual Residence of Decedent												
	Marylar In show	tor	10a. State 10b. County Maryland Montgo	omery		y, Town or Lo omac	ocation						10d	, Inside City 1 ☐ Yes	
	h the	Funeral Director	10e. Street and Number				10f. Zip Co	de				10g. Citizen of Wh	at Country	/?	
	13 wit	a	9028 Copenhaver	Drive			2085	4				United S	State	s	
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	.S. 13.	Was Decedent	of Hisp	oanic Orig	gin? (Spe	cify Yes or No- lican, etc.)	14. Race -	American White, etc		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ehow many injurgo-e	र्व	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced				1 ☐ Yes 2 X		Specify:	, , , , , , , , , , , , , , , , , , , ,	noun, oto.,	Specify:	Whit		
2	72 ho	eted	15. Decedent (Specify only highes	s Education grade completed)		16a. Dece	dent's Usual O	ccupati	ion rina most	of working	na	16b. Kind of Busin	ness/Indus	stry	
121	han han	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work d DO NOT use r					District		Colum	bia
2	Hygie ther t	ပိ	17. Father's Name (First, Middle, I	ast)		Clerk	or th			r's Name	/First Middle	Tax Cour	: [
and	antal h	Be C	Pietro Ragusa	231/					_		liceli	waloon oomanio,			
2	should Me mark	၉	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailie	ng Address (St	treet an				r, City or Town, St.	ate, Zip Ce	ode)	
S	nd 2.		Thomas J. Liber	ti/Son								e, Maryla			
Baltimore,	ages 1 and of Height		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		20b. P Gat	Place of Dispo emetery, crea e OI H	natory or other eaven	of		D Janua	ate ary	20c. Location - Ci Silver Sp	ty or Town	n, State	
풀	artme artme ortant injury		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L			20	etery	ddress	of Equilib	10, 2	ert A.	Marylar	id Fun	eral	Home/
Ba	Depa Impo eny ir		1/1/1/1	h	M013	67 F	lockvil lockvil	le,	Inc. Mary	300 1anc	Westo-	Fumphrey Montgomer -2805	y Av	enue	::::::::::::::::::::::::::::::::::::::
8760,	Lifes that the death certificate be executed Ex Signed by the attending physician and detached for use as the burial-transit	dical Examiner	23a. Pert1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiliated events resulting in death) Last	inly one cause on each I	MONI a consequ	uence of):		, symig,			Topinalory and	031,	ln In	pproximate iterval Betw inset and D	eath
.O. Box 6	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be delached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 o	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	Ideath 3□	∃Ectopic pregn ∃ Other (specif					23d. Date of Month		ay Y	e ar
ds, P	luires that n signed b ıld be deta	by	Part II. Other significant conditio	ns contributing to death b	out not resi	ulting in the u	nderlying caus	e given	in Part I.		23e. Did to	bacco use contribu		cause of de	
Records,	e faw requir has been s je 2 should	Completed	Dementia								24a. Was a autop:	sy pric		y findings a letion of ca	
											1 ☐ Yes	2×40 1		TW0	
Vital	siciar certif recto	o Be	25. Was case referred to medical examiner?	Hospital:		FD(0.1)		Other			(Check only or				
of	Attending Physician: The lav r death. ector: Alter this certificate has by the funeral director, page 2	ļ⊢.,	1 No 27. Manner of Death	1) Inpati	IIV	28b. Time of	nt 3□ DOA f 28c.	injury a	4 🗀 19ul			ence 6 Other			
0	nding th: :: Afte e func	ation	1 □Natural 5 □ Pending 2 △Accident investig	ation 12 30/	y Year) 2003	un Kho		Work?	s 2 0	/	Fell -	from c	hai	n	
Division of		Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be an Bloom of In	jury - At ho	ome, farm, str		fice Ho	spita	$a = 1 \frac{2}{q}$	8f. Location (S City or Town 901 Med	treet and Number	or Aural A Len D	oute Numb	ier, Villem
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the est xaminer: On the basis of and manner st	of my kno	wledge, deat	h occurred at the	he time, my opin	, date and nion, deat	d place, a	nd due to the c	ause(s) and mann	er as state	ed. e cause(s))
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and manner st	La	a 2	29c. Li	cense r	nedmur	/ *	2	29d. Date signed (/	Month, Da	y, Year)	
	50		1 Patrion	1 Jourskie	- 7	lag h	and the	Di	519	16	-	Jan. 9,			
			30. Name and address of person v	KO VAY, 6	death (Item	Mont	Print)	Rd.	R	ock	ville,	mD :	108	52	
4	Sta Registi		31. Date filed (Month, Day, Year) JAN 12	2004 37. Regist	rar's Signa مصم	ture	Sport	h							

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:45 P M Robert William Lowe January 8, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1⊠M 2□ F Director 579-14-3860 86 20, 1917 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-1 ehow r than "natural", or Items 23a or 28e-f ebovitos Madigal Examinar mant be notified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 409 Belton Road 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 TXYes 2 □ No
If Yes, Give
Year or Dates: 1940-59 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than eny injury or other traumatic event, Ina M 1 Military Officer Armed Forces 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry John Lowe Jessamine Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Rosalie Lowe/ Wife 409 Belton Road, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 6 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State January 9 * 4 □Donation 5 □ Other (Specify) Metropolitan Crematory 2004 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. oper 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a a consequence of Due to for Examiner death certificate be executed signed by the attending physician and be detached for use as the burial-transit Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions, ontributing to death but no resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Division of Vital 1 Tes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 1 XNatural 5 Pending s after de. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral D 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I ţ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 290. License number e 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NASREEN TAKOMA MANGO 7610 31. Date filed (Month, Day, Year)

JAN 12 2004 32. Rigistrar's Signature State Registrar

		1 - State Registrar	State of Mar	•	Certificate of			Reg. No.	OL	02501
Physici /Medic		Decedent's Name (First, Middle, La	JAMES	MARTI	N		2. Date of De Month	Day	Year LOUY	3. Time of Death A
Examin	er	4a. Facility Name (If not institution, giv		CENTER		or Location of Deat	h	4c. Count	of Death	3
Funeral Director		229-40-0132	ex 7. Age (/ ☐ 7. Age (/	In yrs. last birth	Months Day			rth ay, Year) , 1938	9. Birthpla Country	ce (State or Foreigr y) VA
show	_	Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town	or Location				100	d. Inside City Limits
ith the Maryla or 28e-f shov	Director	VA ACCOMACI		SAXIS	10f. Zip Code			10g. Citizen of		1 X Yes 2 □ No y?
1215-0036 within 72 hours after death with the Maryland ane. ane. hash "natural", or fleme 23a or 28e-f show the Maryland and a Maryland and	Funeral	9001 KEITH S LA	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	er in U.S.	13. Was Decedent of If Yes, specify Cu		pecify Yes or No to Rican, etc.)	USA 14. Rac Bla	ce - Americar ck, White, et	
5-003(72 hours a natural", o	ted by	3 Nidowed 4 □ Divorced 15. Decedent's En	Year or Dates:	16a. D	1 ☐ Yes 2 🛣 No	Ination	diin	Specifi 16b. Kind of B	WILL	
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work don fe. DO NOT use retii NATERMAN	e auring most or wo	rking	SEAF	OOD	
	To Be C	17. Father's Name (First, Middle, Last) LESLIE MARTIN,					me <i>(First, Middle</i> A EVANS	, Maiden Surnar	ne)	
iore, Marylani ges 1 and 2 should be t of Health and Mental If item 27 is marked o or other treumatic eve	-	19a. Informant's Name/Relationship (19b. N	Mailing Address (Stree		OX 134,			
a a e e		20a. Method of Disposition 1 Burial 2 Cremation 3 4 One 5 Other (Specific	Removal from State	cemetery,	isposition (Name of crematory or other pl		Date 4/04	SAXIS,		n, State
Baltimore permit. Pages 1 Department of F Importent: If ite any injury or ot once.		21. Signature of Suneral Service Licer		,	22. Name and Add	ress of Facility TH	ORNTON	FUNERAL	HOME	VA 23421
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	· Li	t enter the mode of dy	ring, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	b. Communit		/	n (Cr				
xecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a control of the control of							
68760, illicate be executed g physician and as the burial-transit	edical E	(d							
O. Box	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су			te of delivery inth D	ay Year
rds, P.		Part II. Other significant conditions of radiation Meym	1	not resulting in th	ne underlying cause g	iven in Part I.		obacco use cont		cause of death?
	Completed by	gnemia					24a. Was autor perfo	osy ormed?	orior to comp death?	y findings available eletion of cause of
of Vital F Physician: The rthis certificate ral director, page	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ☐ ER/Outp	atient 3 DOA		ath Check on c	one		
/ision of Attending Phy r death. sctor: After thi by the funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		ne of 28c. Injury			how injury occur		
Divisio	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	- At home, farm Specify)	, street, factory, office	19339-8	28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural F	Route Number,
Divisi To the Hospitel or Attention 24 hours after death To the Funarel Director:	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of miner: On the basis of exand manner stated	amination and/o	leath occurred at the or investigation, in my	ime, date and place opinion, death occu	, and due to the cred at the time,	cause(s) and ma date and place,	inner as state and due to th	ed. ne cause(s)
To the within 2 To the comple	N.	29b. Signature and title of certifler	n As			59368		29d. Date signed	(Month, Da	y, Year)
2 H.4		30. Name a odress of person o	completed cause of death	h (Item 23a) (Ty	1	iber 1	3.11.01			
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	South	11	-:-			

		•	For State Registrar	State of Marylar	-	rtment of H tificate of L			ene 20	04 02505
*	Physici /Medic		1. Decedent's Name (First, Middle, Last, Margaret Farrel	l McDonough				2. Date of Death Month January		Year 2:20 AM ^M
	Examin		4a. Facility Name (If not institution, give Casey House-Mont;	gomery Hospic		Rockv:				omery County
il dig	Funeral Director		5. Social Security Number 578-12-5471 Usuel Residence of Decedent	7. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	^(ear)	9. Birthplace (State or Foreign Country) Washington, DC
	72 hours after death with the Maryland naturel; or items 23a or 28a-f show disal Evarrines must be rudified at	Director	10a. State 10b. County Maryland Montgomer		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	23a or 2	rai Dir	9210 Kentsdale Dri			10f. Zip Code 208			USA	
980	urs after deal al', or itams ; Evaminer mu	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	İ	Vas Decedent of Hi f Yes, specify Cubai I ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, k, White, etc. Caucasian
21215-0036	within ane. then "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done do DO NOT use retired	luring most of work	ring	Sb. Kind of Bus	siness/Industry
Maryland 2	buid be filed Mental Hygie arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Philip I. Farrell		DOOKK	eeper		e (First, Middle, Ma Willkie		
Mary	nd 2 shoul lith and Ma 27 is marl r traumati		19a. Informant's Name/Relationship (7) Patricia McKee-Kas		1			a <i>i Route Number, C</i> hesda, Ma		
Baltimore,	m O - L		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ F ↑ 4 □ Donation 5 □ Other (Specify)	Temovan Irom State		sition (Name of natory or other place Memorial				City or Town, State
Balti	permit. Page Department of important: if any injury on		21. Signature of Funeral Service Licens		22	. Name and Addres	s of Facility		0	ls Church ch, Va. 22046
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or compositions, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the dea ne cause on each line. a. <u>Dementia</u> Due to (or as a consec		er the mode of dying	g, such as cardiac	or respiratory arres	d,	Approximate Interval Between Onset and Death Years
68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, Jary, leading to minediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	b. Debility Due to lores a consect. Con estive Due to (or as a consect.)	Heart	Failure				Years
O. Box	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn 1	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery th Day Year
<u>α</u>	The law requires that the ste has been signed by th bage 2 should be detache	þ	Part II. Other significent conditions co	ntributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.			bute to the cause of death? 3 Probably 4 Unknown
Il Records,		Completed						24a. Was an autopsy performe 1 Yes 25	ed? pi	Vere autopsy findings available rior to completion of cause of eath?
Vital	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	it 3□ DOA Othe	ar-	th <i>(Check only one)</i> ome 5 🗆 Residen		r (Specific) II a == i ==
ion of	ding After funer	-	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	A-	
Division	i Si te o	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factory, office		28f. Location (Stre City or Town,		or or Rural Route Number,
	he Hospital n 24 hours a he Funeral (Medical	29a. Certifier (Check only one)	sicien: To the best of my kn iner: On the basis of examin- and manner stated.	owledge, deatl ation and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and mar e and place, a	nner as stated. nd due to the cause(s)
-	A	Σ	29b. Signature and title of dertifier	M	MO	29c. License	9 number 5635			(Month, Day, Year) 4, 2004
	6		30. Name and address of person who co	The second	E-15'	Print)		20 60	1782	., 2007
N R	Sta	ate	Joseph Kaplan, MD 31 Date filed (Month, Day, Year)	32. Registrar's Sign	ature A	Asas de	KOCKVII	ie, naryi	JIII	

		1 - For State Registrar	State of Ma	rylan			nt of H <i>te of L</i>		and M	ental Hy	giene Reg. No		, 02	506
Physic	ian	Decedent's Name (First, Middle, Last)							2. Date of De Month	Da		3. Time o	
/Med		Katherine Marcellu								Januar) A ^M
Exami	ner	4a. Facility Name (If not institution, give						Location o	f Death			. County of Dea		
		199 Rollins Ave. #		(In vrs. I	ast birthday)		KVill er 1 Year	e If Under 2	24 Hrs.	8. Date of Bir	rth	ntgomer		or Foreign
Funeral Director]м 2 Х]F	86	Yrs.	Months		Hours	Min.	Month, Da May 27	y, Year) 19	17 Mar	thplace (State ountry) yland	or r orangir
0		Usual Residence of Decedent									,			
urylar nhow	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	•
8a-1 a	Directo	Maryland Montgomer	У	Rock	cville								L	2 🗆 No
with th	를 교	10e. Street and Number				10f. Z	ip Code				10g. Cit	tizen of What C	ountry?	
s 23g	era	199 Rollins Avenue	#327 12. Was Decedent Ev	vor in II	S 12 h	Non Doo	2085		nin? (Cno	cify Yes or No		ted Sta		
s within 72 hours after death with the Maryland liene rthan "natural", or Items 23a or 28a-f ahow the Medical Examinat must be notified at	Funeral	1 Never Married 2 Married	Armed Forces?		11	Yes, sp	ecify Cubai	n, Mexican,	, Puerto F	Rican, etc.)		Black, Whi		
urs al	þ	3 Widowed 4 □ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1	Yes	2X No	Specify:				Specify:Whi	te	
72 ho	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Us	ual Occupa	ition luring most	of workin	10	16b. K	ind of Business	/Industry	
9 9	nple	Elementary/Secondary (0-12)	College (1-4or 5+	·)	life. L	DO NOT	use retired,)	OI WOIKIII	y				
filed within I Hygiene. other than " ant, the Me	Cor	12			Homema	aker						n Home		
2 7 5	Be	17. Father's Name (First, Middle, Last)								(First, Middle	, Maiden	Sumame)		
and Mental B and Mental B a marked of	2	Hugh Marcellus 19a. Informant's Name/Relationship (T)	an Daint		10h Maili-	- 4-1-1	- (Chana)	Matt			0	or Town, State,	7. 0. 4.1	
th and		Irene L. Roberts/S				-								1075
of Health and Ment fittem 27 is marked rother treumatics		20a. Method of Disposition	Ister	20b. P	lace of Disno:	sition (Na	me of			ad, Ellate ry 12,		ge, Mar		.10/3
permit. Pages Department of the important: If its any injury or of once.		1 N Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Par	emetery, cren klawn	natory or Memo	rial	a) J			Do al	1	M =1 =	لدمد
artme ortar injur		21. Signature of Funeral Service Licens			Park 22	. Name a	ind Addres	s of Facility	2004 Robe	rt A.	Piimr	kville, hrey Fu	meral	Home/
		15 PS	111	м013	Ro	ckv	ille,	Inc.	300	West 1	Mont	gomery 5	Avenue	
	4	23a. Part1. Enter the disease, or complishock, or heart failure. List only o	lications that caused to	he death									Approxima Interval Be	
hysician		Immediate Cause (Final disease or condition	Pneumoni										Onset and Weeks	
/Medical		resulting in death)	a. Due to (or as a		uence of):								WEEKS	
xaminer		Sequentially list conditions,	b Coronary	Art	ery Di	Lseas	se						Months	/Years
=	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ience of):									
and trans	Examin	Cause (Disease or injury) that initiated events resulting in death) Last	c											
physician and the burial-transit			Due to (or as a	consequ	ience or):									
physics the	dlcal		d				· · · · · · · · · · · · · · · · · · ·							
attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnai	ncy							23d. Date of de	iven	
atter d for t	clar	in the past 12 months?	1☐Live birth 2 4☐Pregnant at ti			Ectopic p Other (s	pecify)					Month	,	Year
by the	hys	9 □ Unknown	9□ Unknown											
been signed by the s should be detached	by P	Part II. Other significant conditions co	ntributing to death but	not resu	ılting in the un	derlying	cause give	n in Part I.		23e. Did t	obacco u	use contribute to	the cause of	death?
en sig										10	Yes 2]	XNo 3∏P	obably 4 🗌	Unknown
as be 2 sho	Completed									24a. Was		24b. Were at	Itopsy findings	available
ate ha	E OC									perfo	med?	death?	2□ No	2036 OI
r this certificate has l ral director, page 2 s	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only	47			
8 0	2	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient		ER/Outpatien			4 🗀 IVUI	sing Hom	e 5 X Resi	dence	6 □Other (Spe	cify)	
19 e	00:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury		28c. Injury Work			8d. Describe	how injur	y occurred		
after death. I Director: Af d in by the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	On Blace of Initial	411		М		es 2□N		Of Leasting (111		,
Direc Direc in by	Certification:	4 Homicide determined	28e. Place of Injur- building, etc.	y - At ho (Specify	me, farm, stre	eet, facto	ry, office		21	81. Location (City or To	Street an wn, State	d Number or Ri)	ıral Route Nun	nber,
eral l		29a. Certifier 1X Certifying Phy	sicien: To the best of	my knov	uladaa daath	00011550	t at the tim	o dato and	t place, as	nd due to the	221120(2)	and manner of	stated	
24 hours a Funeral letely filled	edical		ner: On the basis of e and manner state	examinat	ion and/or inv	estigatio	n, in my op	e, date and inion, death	h occurre	d at the time,	date and	place, and due	to the cause(s)
within 24 hours after To the Funeral Dire completely filled in the	₹	29b. Signature and title of certifier				29	c. License	number			29d. Dat	te signed (Mont	h, Day, Year)	
, - 0		Malay B. No	inavaly.	3	O		D0051	1119			Janu	ary 8,	2004	
,		30. Name and address of person who co		ath (Item	23a) (Type. I		20071	/			Jane	y 0,		
		Uday Nanavaty, M.					#221	. Roc1	kvil	le. Mai	rvlar	nd 20850)	
	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signat	ure /									
Regist	rar	IAN 12 200	14 Deper	na	Ø	10	acks							

	ş.		For State Registrer	State of Maryl		irtment of H <i>tificate of L</i>			ene 1 1 L	02508
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Forest L	.ee	Morris		Jr.	JANUARY	20, 2004	22:20 M
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
			MEMORIAL HOSPITAL			CUMBERL			ALLEGANY	
	Funeral		5. Social Security Number 6. S		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	ear) 9. Bir	thplace (State or Foreign
	Director		212-32-8174	XM 2□F 69	Yrs.			Nov 18,	1934	INID
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c	City, Town or Lo	cation				10d. Inside City Limits
	eho	5	MD Allega			perland				1 ∑Yes 2 ☐ No
	288-1	ect	10e. Street and Number			10f. Zip Code		100	. Citizen of What C	ountry?
	With the or	ā	21 Pennsylvania A	Avenue			21502		USA	
1	filed within 72 hours after death with the Maryland Hygiene, than "natural", or itema 23a or 28a-f show ent, the Madical Examination notified at	by Funeral Director	11. Marital Status	12. Was Decedent Ever	n U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba		ecity Yes or No-	14. Race - Am	
	Iter d	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 XYes 2 ☐ No If Yes, Give 19	i			Rican, etc.)	Black, Whi	
3	urs a		3 ☐ Widowed 4 ☐ Divorced	If Yès, Give Year or Dates: 19	53-1957	I□Yes 2ĂNo	Specify:		Specify: W	nite
5	2 ho	ted	15. Decedent's Ed (Specify only highest gra	ducation	16a. Deced	lent's Usual Occupa kind of work done o DO NOT use retired	ation furing most of work	dina 16	b. Kind of Business	/Industry
V	e.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)						Chanana
V	ed wi	Completed	12		Owner	r/Operator			loving and	Storage
	ould be filed Mental Hygi arked other atic event,	Be	17. Father's Name (First, Middle, Last) Forest Lee Mor					ne (First, Middle, Ma Cartruda	Hamilton	Morris
<u>Z</u>	ould Men Parke	ို			401 14 17					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hydiene. Department of Heath and Mental Hydiene. Immortant: If time 77 is marked other than "natural; or itema 23a or 28a-1 ehow any injury or other traumatic event, the Madical Examination and building at once.	1	19a. Informant's Name/Relationship (wife wife	196. Mailir 21 F	Pennsylvai	nia Avenu	ie Cumbe	City or Town, State, erland	1D 21502
a) a	1 and 2 Health tem 27				b. Place of Dispo				c. Location - City or	
_	Pages nent of hunt: if its		20a. Method of Disposition 1 Burial 2 Cremation 3 C	Removal from State	cemetery, crer	matory or other place morial Park	e)		Cumberla	
Saltimor	t. Pa		*4 Donation 5 Other (Specific	y)					Cambena	IG IVID
ם מ	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licer	A Cum/		Name and Address				00
			23a. Part. Enter the disease, or com	olications that caused the	leath. Do not ent				nd, MD 215	Approximate
			shock, or heart failure. List only	one cause on each line.	304	o	3, 00011 00 00101		,	Interval Between Onset and Death
	mysician /Medical		disease or condition resulting in death)	a. ESOPHAGEA						4 MONTHS
	Examiner			Due to (or as a cor		TTE DIT MON	IADV DICI	A CE / EMDIS	ZCEMA	
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. CHRONIC C		VE PULMUI	NAKI DISI	LASE/EMPH	ISEMA	
	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury							
2	exect n and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a cor	sequence of):					
8/60	ficate be executed physician and s the burial-transit	cal	(d					- 6	
Q	iificat g ph) as th	ed								
ROX	death certift e attending id for use as	ician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		Ectopic pregnancy			23d. Date of de	
	deat	icia	in the past 12 months?	4 Pregnant at time		Other (specify)			Month	Day Year
J.	that the death certifued by the attending of detached for use as	Physi	9 Unknown							
ທົ	Se De	by F	Part II. Other significent conditions of	contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.			to the cause of death?
Hecord	w require been si should b							1 KJ Yes	2 No 3 F	robably 4 Unknown
ပ္သ	e law r has be je 2 sh	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
ř	The ate ha	mo.						performe	ed? death? ∃No 1 ☐ Ye	s 2 No
Vital	sician: The la certificate ha irector, page 2	Be (25. Was case referred to medical examiner?					th (Check only one,	1	
010	D 0.	10	1 ☐ Yes 2 ☑ No		2 ER/Outpatier		4 🗆 14012119 11		ce 6 ☐Other (Sp.	ecify)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	Wor		28d. Describe how	injury occurred	
<u>0</u>	Attendi death. ctor: A y the fu	cati	2 Accident investigatio				Yes 2 □No			
Division	or Atten after deatl Director: in by the	Certification:	3 Suicide 6 Could not be determined		At home, farm, str pecify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or F State)	Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune			 	the section is				(-)	a stated
	Hosi 24 ho Fune Fune	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exer	nysician: To the best of my miner: On the basis of exa	knowledge, deat mination and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	e and place, and du	e to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	()	29c. Licens	e number	296	d. Date signed (Mor	ith, Day, Year)
	2 ± ₹ 8		1/1	on lell	de				11221	M.
			20 11-	completed	(thom 22=) 7"		60478		11-11	7
	12	-	30. Name and address of person who AHMAD, AFAQ, M.D				CITMEED	T.AND MD	21502	
aPl.	1 V	ate	31. Date filed (Month, Day, Year)	32. Registrar's		SULTE IUZ	, COMBER	TILL 6 CHARLE	_1304	
1		atc		2004		1	Y			

			1 - For Amend Item#10cpe:	State of Maryla rFHC827 1/30/04	nd / Depa EW <i>Cel</i>	artment of H	lealth ar Death	nd Mental Hy	giene Reg. No.	04	02509
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year .	3. Time of Death
	/Medic		Robert Clinton					1 -	05-	04	22:05 M
j.	Examin	er	4a. Fecility Name (If not institution, give s		A 1	4b. City, Town, o			4c. County		V.14.)
			SACRED HERAT 5. Social Security Number 6. Sex		A L.s. last birthday)	CUM (If Under 24	Hrs. 8 Date of Bir	HLL th		
	Funeral Director			M 2□F	72 Yrs.	Months Days	Hours	Min. June 16	iy. Year)	Va	plece (State or Foreign ntry)
	ס		Usual Residence of Decedent		7 2				,		
	arylar show	_	10a. State 10b. County		City, Town or Lo					1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	88-1.	Director	WV Mineral	- P	luefiel		ew Cre	ek	40-02		
	with t	ä	10e. Street and Number			10f. Zip Code			10g. Citizen of V USA	vnat Coul	ntry /
	eath	Funerai	HC=75 Box 45	2. Was Decedent Ever in	U.S. 13.	267 Was Decedent of H		n? (Specify Yes or No		e · Americ	can Indian,
' O	r Iten	표	1 ☐ Never Married 2√CMarried	Armed Forces? 1 ☐ Yes 2 🔀 No		If Yes, specify Cub-	an, Mexican, F	Puerto Rican, etc.)		k, White,	etc.
ő	rel', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes 2√2 No	Specify:		Specify	· Wh	nite
5-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28s-f show the M.digal Exami her must be nutified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup	during most o	f working	16b. Kind of Bu	ısiness/In	dustry
2121	vithin han	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	•		Trans	ei+	
7	filed v Hygie other t		17. Father's Name (First, Middle, Last)			Bus Drive		Name (First, Middle	l		
Maryland	d be i	o Be	Asa Henry McFarl	and				tha Ella			
2	should and Men a marke umatic	၉	19a. Informant's Name/Relationship (Typ		19b. Mailie	ng Address (Street		or Rural Route Numb			Code)
Ž	and 2:		Ronna J. McFarlan	d (wife)	HC-	75 Box 4	5 News	Creck, Wy	26743		
J.	s 1 a		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other plan		/8/04	20c. Location -	City or To	own, Slate
Ē	Pages nent of ant: If its ury or o		Nation 2 ☐ Cremation 3 ☐ Records 4 ☐ Donation 5 ☐ Other (Specify)		.Zion C	Cemeterv	1/	7 0 7 0 4	August	a, W	<i>I</i> V
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Madical Exambles in ust be notified at once.		21. Signature of Funeral Service License	00) 22	Name and Addre	ss of Facility	Home Hamp.	110 115	5 E.	Birch Lane
_	40 5 % a		ames K	Syles		rickee ru	nerar r	nome namp.	Romr	iey,	WV 26757
		1	23a. Pert1 Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.				rdiac or respiratory a	rrest,	-	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	LUN		ANCE					7 Years
	Examiner			Due to (or as a conse	equence of):	uctive	Pula	nonalu d	iseas	a	10 19915
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):		10111	101741 9 27	12642		10_1003
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							1	
oʻ	e exection ar		resulting in death) Last	Due to (or as a conse	equence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical	€ d								
Box 6	entifica ding ph	Physician/Med	IF FEMALE:	3c. If yes, outcome of preg	nancy						
Bo	aath c attenc for us	ian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)	4		23d. Dat Mor	e of delive nth	ery Day Year
P.O.	that the death certific led by the attending p detached for use as	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	death 3	_ Cities (specify) _					
	res that igned by be deta	by Ph	Part II. Other significant conditions con		sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contr	ribute to ti	he cause of death?
Records,	v require: been sig should be	d be	High Bloc	od Press	Ure			_ 1,2	ves 2□No	3 🗌 Prot	pably 4 Dunknown
000	aw requisible been 2 shouk	piet	1	3.				24a. Was	an 24b. V	Vere auto	ppsy findings available impletion of cause of
Ä	The I	Completed						autor perfo	rmed2/ c	lealh?	2 No
of Vital	Physician: The lav this certificate has ral director, page 2	Bec	25. Was case referred to medical examiner?				26. Place of	Death (Check only o	A		
× ×	hysic his co	ပ္	1 □ Yes 2 ☑ No H		☐ ER/Outpatier	-	4 🗀 NUISI	ing Home 5 🗆 Resi			(y)
no Duc	After in erg	inol	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor			how injury occurr	ed	
Division	Attending Physician: ir death. ector: After this certification in the fureral director.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm str		Yes 2 □ No	-	Street and Numbe	er or Rura	al Route Number
<u>≥</u>	after A	Ce tification:	4 ☐ Homicide determined	building, etc. (Spec	cify)	cot, ractory, office		City or To			
	pspits hours ineral y filled		29a. Certifier 12 Certifying Phys	ician: To the best of my ki	nowledge, deat	h occurred at the tir	me, date and p	place, and due to the	cause(s) and ma	nner as s	tated.
	he Ho in 24 ihe Fu pletel	edicai	(Check only 2 Medical Examir one)	ner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, death	occurred at the time,	date and place, a	and due to	o the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled " by the fur eral	Σ	29b. Signature and title of certifier	0.1: UNS		29c. Licens			29d. Date signed	(Month,	Day, Year)
•			Deorge Henn	,	11	do0:	5947		Janua	1-	tin 12004
			30. Name and address of person who co	1	em 23a) (Type. 725 B	Print)	10 (0)	Road C.	inharla	ind	7Th 12004 MO21502
	Sta	ite	31. Date filed (Month, Day, Year)	32. Register's Sig	nature	131100 11	101 13 M	invari, a	VAINFOCI IN	CILVI	110 21307
₹.	Regist			2004		Last 3					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lois Hurley Nickerson JANUARY 2004 12:30 PM 13 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WICOMICO NURSING HOME WICOMICO SALISBURY 8. Date of Birth (Month, Dey, Year) April 19, 1915 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 1 □ M 2 X F Maryland 88 219-05-9038 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f ahow the Medical Examiner rount be rigitlied at 1 ☐ Yes 2 No Wicomico Salisbury Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 7481 Titleist Dr. 21801 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 white Specify: Specify: δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) electronics assembly line worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Peges 1 and 2 should be Department of Health and Mental is Important; if Item 27 is marked any injury or William O. Hurley Anna Bradley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) daughter 7481 Titleist Dr., Salisbury, MD Janice Pritchett Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State East New Market Cem. 1/16/04 East New Market, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service (Acensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD my 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year tot in the past 12 months? 1 ☐ Yes ■ No 4 Pregnant at time of death 5 Other (specify) ö detached **q**□ Linknown <u>a</u>: sate has been signed bage 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown DISENSE COFONARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 TYes 2 No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certify 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Sign itle of certifier JANUARY 13, 2004 DET 00% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 SALISBURY MOHAN BHAT M.D 614 EASTERNSHORE DR. 31. Date filed (Month, Dey, Yeel) State Registrar

		1 - State Registrar	laryland / Dep		alth and M	ental Hygi	ene2004	02512
Physici /Medio		1. Decedent's Name (First, Middle, Last) JAMES ANDERSON NGARUI				2. Date of Death Month January	12, 2004	3. Time of Death 8:15 P M
Examir	er	4a. Facility Name (If not institution, give street and number Shady Grove Adventist Hosp		4b. City, Town, or L Rockville	2		4c. County of Death Montgome:	
Funeral Director		216-57-6905 ¹፟፟፟፟M 2□F	ge (In yrs. last birthday 75 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 28,	Year) 9. Birth 1928 Ken	place (State or Foreign intry) iya
Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Md. Montgomery	10c. City, Town or L Gaithers					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
h with the	Funeral Director	10e. Street and Number 858 Flegler Drive		10f. Zip Code	0878		g. Citizen of What Cou Kenya	intry?
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Itame 23s or 28s-f show eumatic event, the Madical Examinational Lean-tiffed at	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 Married 17. Was Decedent Armed Forces 1 Yes 2 Married 18. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Blace	, etc.
filed within 72 ho Hygiene. other than "natur ent, ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+1	edent's Usual Occupation of work done dure DO NOT use retired) ic Health (6b. Kind of Business/In	
uld be filed Mental Hygia srked other atic event, II	To Be Co	17. Father's Name (First, Middle, Last) Kamunya Kamau			8. Mother's Name Watee Ma	(First, Middle, Ma		
alth and I		19a. Informant's Name/Relationship (Type, Print) Beth Thanji Ngaruiya (Wife		ling Address (Street and Flegler Dri				
permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked any injury or other treumatic evonce.		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)		position (Name of ematory or other place) ys Estate	Jan. D	_{NT} مرک	oc. Location - City or T arobi, Ken	
permit. Departitmport		21. Signature of Funeral Service Licensee		22. Name and Address 10 East Dee	Dev	ol Funer or. Gaith		1d. 20877
Physician /Medical Examiner	ılner	Sequentially list conditions b.	a consequence of):		M CUM			Approximate Interval Between Onset and Death
The law requires that the death certificate be executed tte has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physiclan/Medical Examiner	that initiated events resulting in death) Last		□Ectopic pregnancy			23d. Date of deliv	,
at the dea by the at stached fo	hysic	9 Unknown		Other (specify)			Month	Day Year
w requires that been signed to should be deti	by	Par II. Other significant conditions contributing to death	but not resulting in the t	underlying cause given	in Part I.	T	cco use contribute to t	1 1
	e Completed	25. Was case referred to medical				24a. Was an autopsy performe	prior to co death? ☐No 1 ☐ Yes	opsy findings available empletion of cause of
ing Phye	To B	examiner? 1		ont 3 DOA Other: 28c. Injury a Work?			ce 6 □Other (Specia	<i>(</i> 5)
vital or Attend urs after death irel Director: / lled in by the f	Certification:	4 Homicide building, e	jury · At home, farm, st tc. <i>(Specify)</i>			City or Town,		
To the Hospital of within 24 hours af To the Funerel completely filled in	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of and manner s	of examination and/or in	nvestigation, in my opin	ion, death occurre	d at the time, date	e and place, and due t	o the cause(s)
Z Military S		29b. Signature and title of certifier	ar	29c. License n	3224	JA	I. Date signed (Month,	3,2004
		30. Name and address of person who completed cause of R Ancham MUS SOW &	amons	Print)	303	Rocko	elle mo	20852
Sta Registr		31. Date filed (Month, Day, Year) JAN 1 4 2004 32. Regist	rar's Signature	Sparks	/			

			For State Registrar	State	of Maryla		artment of F		nd Mental I	lygien Reg. Ne	6. 11 11 14	02513
	Dhysisi	an.	1. Decedent's Name (First, Middle, I						2. Date of Month			3. Time of Death
	Physici /Medio		Robert D		nger		1		Janu	ary 1	2, 2004	2130 M
Н	Examin	er	4a. Facility Name (If not institution, g Shady Grove Adv			.1	4b. City, Town, or Rockvil		Death		County of Death	
- 6	Funeral			Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of (Month)	Birth Day, Year	Montgomer	place (State or Foreign ntry)
	Director		523-12-2765	1 X)M 2□F	8	4 Yrs.	Months Days	Hours	Marci	n 28,	1919 Sout	h Dakota
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	ocation					10d. Inside City Limits
	Mary	tor	Maryland Montgo	merv	Ro	ckville						1 ☐ Yes 2 🕅 No
	death with the Maryland rms 23a or 28a-f show	Director	10e. Street and Number		· · ·		10f. Zip Code			10g. Ci	tizen of What Cou	ntry?
	s 23a	eral	14627 Crossway	7	adas Francis	11.6	20853		0.00	-	ited Stat	
9	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Memtal Hygiene. The filem 21s marked other than "natural", or items 23s or 28s-f show other traumatic event, it is Medical Frammer must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F	2 No Wo		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🂢 No	Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ameri Black, White, Specify:	etc.
215-0036	2 hou		15. Decedent's	Education		16a Dece	dent's Usual Occup	ation		16b. K	Whit Gind of Business/In	
7	ithin 7 ie. ien "n	Completed	(Specify only highest of Elementary/Secondary (0-12)) (1-4or 5+)	(Give	kind of work done of DO NOT use retired	du <i>ring m</i> ost oi 1)	f working			·
7	iled wi		17. Father's Name (First, Middle, La	5+	-	Geo1	ogist	10 14-4	No. of the second		ederal Go	vernment
Maryiand	d be fi	To Be	Harvey Harlow N						Name (First, Mid 7 Adeline			
a Z	shoul and Mari umati	Ĕ	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street a	and Number o	or Rural Route Nu	mber. City	or Town. State. Zic	Code)
Ξ,	and 2 ealth a n 27 ls		Robert H. Ninin	ger/Son			Box 393/1 Creek	.059 Li Colora	ttle Wood do 8165	dy Cr	eek Road	
baitimore,	or of H	93	20a. Method of Disposition 1 □ Burial 2 X Cremation 3			Place of Dispo cemetery, crei ntgomer	sition (Name of natory or other plac 'V		nuary 17	20c. L	ocation - City or To	own, State
	permit. Pages to Department of the Important: If its any injury or ot once.		*4 □ Donation 5 □ Other (Special Sign Time and Provide Life Service L		Cr	ematori	iim. Inc.	20		Bet	hesda, M	aryland
ä	Per Per Per Per Per Per Per Per Per Per		1 while	Borr	_ MO	0803 R	ockville, ockville.	Inc. Mary1	300 West	50-78	gomery A	neral Home/ venue
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that by one cause on	caused the de-							Approximate Interval Between
E	Physician		Immediate Cause (Final disease or condition	a Pn	eumoi	Tia					u	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Sus to	(or as a sonse	quanes of):						
	acuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.								
8/00,	rcate be executed physician and the burial-transit		resulting in death) cast	Due to	(or as a conse	equence of):						
00	ficate p phys	edical		d								
ŏ	h certi	M/us	IF FEMALE: 23b. Was decedent pregnant		itcome of pregr		Ectopic pregnancy				23d. Date of delive	эгу
<u>п</u>	e deat	Physiclan/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		nant at time of		Other (specify)			-	Month	Day Year
ŗ	that the ed by detact	P.	Part II. Other significant conditions	contributing to o	leath but not re	sulting in the u	nderlying cause give	en in Part I.	23e. D	d tobacco	use contribute to the	ne cause of death?
cords,	quires on sign uld be	ed by							T)			ably 4 Unknown
ာ သ	law re as bec 2 sho	Completed							24a. W	as an itopsy	24b. Were auto	psy findings available mpletion of cause of
	: The cate h : page	Con.							pe 1 ☐ Ye	normed?	death?	
VII	sician certifi rector	o Be	25. Was case referred to medical examiner?	Hospital:			Othe	\r:	Death (Check on			
5	y Phy er this eral d	\vdash	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	28c. Injury	at Nursii	ng Home 5 ☐ Re 28d. Describ		6 □Other (Specify ry occurred	y)
SION	ending sath. or: Aft	atlo	1 Natural 5 Pending 2 Accident investigati	on	nth, Day Year)	Injury	M 1 1	res 2 □ No				
Š	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place	e of Injury - At ling, etc. (Spec	home, larm, str cify)	eet, factory, office			(Street an Town, State	nd Number or Rura)	l Route Number,
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours alterd ceath. within 24 hours alterd ceath. To the Functial Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier 1 Certifying F	Physician: To the	e best of my kr	nowledge, death	occurred at the time restigation, in my op	e, date and p	lace, and due to the	ne cause(s)	and manner as st	ated.
	thin 24 thin 24 the F mplete	Medi	29b. Signature and title of certifier	and man	ner stated.	and of the	29c. License		Journal of the (III)			
			Caintin Ro.	G. Aln	we m	0	DDOS				te signed (Month, a	
2	Dtl		30. Name and address of person wh		se of death (ite	em 23a) (Type.	Print)				uary 12,	
			Cristin Darker	Home	mp	9901 M	redical Ce	nter Dr	ive Roc	KVILLE	mo 21	0850
	Sta Registra		31. Date filed (Month, Day, Year)		egistrar's Sigr	nature 4	Source	A				

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month OPPENHEIM **EDWARD** E . JANUARY 2004 /Medical 12:33 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Director 006-10-7963 84 OCT 17, 1919 MAINE Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ntal Hygiene.

od other then "natural", or itama 23a or 28a-f show
event, the Mudical Examinar must be notified. 1 Yes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 15217 CARROLTON ROAD 20853 UNITED STATES Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If flem 27 is marked other than "natural", or itama 23 ury or other traumatic event, it a Mudical Examinal must Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∑Yes 2 □ No WWII If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OPPENHEIM BENJAMIN FRANCES FRIEDMAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DR. WILLIAM L. OPPENHEIM, SON 124 OUTRIGGER MALL, MARINA DEL REY, CA 90292 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Deportment Page Important: If Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 1/11/04 OLNEY, MARYLAND 21. Signature of Funeral Service DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Donald 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION SUDDEN /Medical Due to (or as a consequence of) **Examiner** CORONARY ARTERY DISEASE YF. RS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit MYOPATHY YEARS Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1□ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🖾 EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No Certification; To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ⊠Natural 2 ☐ Accident 5 Pending To the Funeral Director: Aft

To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ma D33844 JANUARY 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. VASSALLO, M.D., 5454 WISCONSTN AVENUE, #925 CHEVY CHASE, MD 20815 31. Date filed (Month, Day, Year) 3 Registrar's Signature State Registrar JAN 12 2004

			For State Registrar	State of Marylar		artment <i>tificate</i>			ind Me		giene Reg. No.		02515
			Decedent's Name (First, Middle, Last)	D. C. =					2	. Date of Dea Month	ath Day	Year	3. Time of Death
	Phýsici /Medio		RAYMOND	OWENS						JAN	9	2000	+ BIEDW
14 0	Examir		4a. Fecility Name (If not institution, give st		0			Location o	_		4c.	County of Deeth	
			Howard Corney			If Under		If Under 2		Data of Bird			
	Funeral		5. Social Security Number 6. Sex 1 X	7. Age (In yrs. 73	Yrs.	Months	Days	Hours	Min.	(Month, Day A112 • 2	Year)	930 Wash	pplace (State or Foreign untry) ington, DC
14	Director		Usual Residence of Decedent								,		
	yland		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	e Mar	ctor	Maryland Howard	Со	lumbia								X Yes 2 No
	请 9c 28	Ole e	10e. Street and Number			10f. Zip				i i		izen of What Cor Led Stat	,
	afh w	Funeral Director	5068 Southern Star		10 10		044		1-0 (0			14. Race - Amei	
	item item	nue	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U Armed Forces? 1 [XYes 2 No 19	48-	f Yes, spec	rfy Cubar	spanic Origin, Mexican	, Puerto Ri	ty Yes or No- can, etc.)		Black, White	
36	irs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 19		1 ☐ Yes 2	2 No	Specify:				African	American
215-0036	72 hours after death with the Maryland naturel', or items 23a or 28a-f ehow disal Exactinet must be notified at	ted	15. Decedent's Educa		16a. Deced	dent's Usua kind of wor	I Occupa	tion	of working			ind of Business/I	
218	within 7 iene. then "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT us	e retired)	uring most	OF WORKING	'		1 1 . 0 -	
7	filed wi Hygien ther th	5	12		Cle	rk							overnment
pur	be fill	Be	17. Father's Name (First, Middle, Last)						rs Name (ie Ow	First, Middle,	Maiden	Sumame)	
<u> </u>	2 should be f and Mental F ie marked of raumatic ever	은	unavailable 19a. Informant's Name/Relationship (Typ)	e Print)	19h Marlin	na Address	(Street a				v. City o	r Town, State, Z	in Code)
, Maryland	and 2 s aith an 3 27 ie i er traui		Gloria Owens (Wi									nbia, MI	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparation of Health and Mental Hygiene. Deparation of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or items 23a or 28a-1 show among injury or other traumatic event, the Medical Examinat must be notified at ODGS.		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Re	moval from State	Place of Dispo cemetery, crem • Linco	natory or of	ther place		Da 1/15/			ntwood,	
ij	artme ortani injury		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee									al Servi	
Ba	permif Depar Impor any in		Thomas M.	lyhur	7	400 G	eorg	ia Av	e. N.	W., Wa	sh.		20012 Approximate
	Physician and physician and physician and physician and the burial-transit	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect quence of): PS (S quence of): Y TM	74K				P. P. S. P. S.			interval Batween Onset and Death 24 (1-P2) 72 (1-P2) 5 () A4/5	
Box 68760,	afh certific ttending p or use as	Physician/Medical E	in the past 12 months?	c. If yes, outcome of pregn 1	al death 3□	Ectopic pro						23d. Date of deliment	v ery Day Year
P.O.	that the death ted by the atter detached for u	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		2 01.10. (0)							
	v requires fhat been signed b should be deta		Part II. Other significant conditions cont	inbuting to death but not res		nderlying ca	ause give	n in Part I.		23e. Did to			the cause of death?
Reco	e law has b	Completed by								24a. Was autop	SY	24b. Were autoprior to death?	topsy findings available ompletion of cause of
ita	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?						of Death (Check only o	-		-
) C	Physician: this certific ral director,	ို	1 ☐ Yes 2 No	74.	ER/Outpatien			4 🗀 140				6 ☐Other (Spec	ify)
no	ding P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work			d. Describe h	iow injur	y occurred	
Division of Vital Records,	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	M eet, factory		/es 2 □ l		f. Location (S City or Tow	Street an m, State	d Number or Ru)	ral Route Number,
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After Completely filled in by the funer	edical Co	29a. Certifier (Check only one) Certifying Physical Examination	cian: To the best of my kn er: On the basis of examinand manner stated.	owledge, death ation and/or in	occurred vestigation,	at the tim	e, date and inion, deat	d place, an	d due to the o	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	ro th within Fo the	Me	29b. Signature and title of certifier				. License				29d. Da	e signed (Month	, Day, Year)
	35		1 Deneth	yang on			0 :	369	74		JA	110 5	2004
(3)		30. Name and address of person who cor	npleted cause of death (Ite	m 23a) (Type.	Print)	4 L	COLI	e Ri	TA F	ws VT	2104 PARCEN	4
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		1				•			
	Regist	rar	IAN 14 200	1 Depera	2	200	eks	/					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) Year **Physician** Jan. 9, 2004

4b. City, Town, or Location of Death

4c. Coun Joao Martins Palmeiro 6:45p /Medical 4a Facility Neme (If not institution, giva street end number) 4c. County of Death Examiner Genesis Eldercare Silver Spring Montgomery If Under 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Sacurity Number 8. Data of Birth (Month, Dey, Year) Birthplaca (State or Foraign Country) **Funeral** Days 1**⊠**M 2□ F 212-64-4019 79 Yrs. Director Jan.24,1924 Portugal Usual Residence of Dacedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Health end Mental Hygiene. Important: If Itam 27 ie marked other than "natural", or Itama 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at Montgomery Silver Spring Md 1 ☐ Yas 2 No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3227 Bel Pre Road 20906 Portugal 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? Race - American Indian, Black, White, atc. 1 ☐ Yas 2 Ñ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 X Yes 2 □ No Specify: þ 3 Ø Widowed 4 ☐ Divorced White Portugal Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elamentary/Secondary (0-12) Construction Laborer 17. Fathar's Neme (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Joao Martins Palmeiro Juliana Martins Gonzales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Victor Palmeiro/Son 1823 Bonifant Road Silver Spring, Md 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/17/04 Faro, Portugal Estoi Cemetery 4 ☐ Donation _ 5 ☐ Other (Specify) unegal Service Li 21. Signature PATTIT MORTINALDI FUNERAL SERVICE, P.A. any in 9241 COlumbia BLvd Silver Spring, Md20910 23a. Pert1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Du Examiner Due to (or es a consequence of) Physician/Medical Examiner pital or Attending Physician: The law raquiras that the death certificete be executed ours aftar death.

erel Director: After this certificate has been signed by the ettending physician and filled in by the funeral director, page 2 should be detached for use es the burial-transit Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaasa or injury that is its and a sort of the control of the con Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. that initiated avants resulting in daath) Last Dua to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 27 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? edicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Data of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not ba Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the ceuse(s) and manner stated. 29a, Cartifian

State Registrar

0

31. Data filad (Month, Day, Yaar) JAN 13

29b. Signature and titla of certifier

30. Nama and address of person who complated causa of deeth (Item 23a) (Type, Print)

Research BLVP Suite 32. Registrar's Signatura oaks

MD

29c. License number

29d. Data signed (Month, Day, Year)

Rockville

		1 - For State Registrar	State of M	iaiylail		artment <i>rtificate</i>			anu iv	iciliai i iy	Reg. No	En W	04	0251
hysicia	an	1. Decedent's Name (First, Middle, La								2. Date of D			Year	3. Time of Death
/Medic		Vertie	Marie		Pat	rick						04		2:35 PM
Examin	er	4a. Facility Name (If not institution, giv						Location o	f Death		40	. County		
		Anne Aundel Med 5. Social Security Number 6. S		ge (In yrs. Ia	et hirthday)	Annap		S If Under 2	24 Hrs	8. Date of Bi	et b	Anne	Aru	
ineral rector			1□M 2□F	82	Yrs.		Days	Hours	Min.	(Month D	y, Year,	21	Cour	place (State or Fore htry) y Land
		Usual Residence of Decedent									,			,
show	-	10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside City Lim
28a-f	Director	MD Anne A	rundel	Ed	gewat									1 TYes 2 □ I
Important: if itam 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic avent, the Modical Examiner must be notified at once.	Ö	1603 Bentley Ro	o d			10f. Zip (L037					izen of W	/hat Cour	ntry?
ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S	. 13. \			spanic Orio	nin? (Spe	acify Yes or N	US		America	an Indian.
Per	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces	?	1		37		Puerto	ecify Yes or No Rican, etc.)			k, White,	
E	by		If Yes, Give 22 Year or Dates:			1□ Yes 2	∆ No	Specify:				Specify:		White
Den	etec	15. Decedent's Education (Specify only highest gradual)			16a. Deced	dent's Usual kind of work	Occupa	tion uring most	of worki	na	16b. K	ind of Bu	siness/In	dustry
N N	d m	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work DO NOT use	retired)	army moot	0. 110.11.	9		77		
1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	ပိ	17. Father's Name (First, Middle, Last,	1		Home	maker		40 14-41	4- 11	/FT:	1	n Ho		
0 D 0 0) Be	Milard Akers	,					Flor		(First, Middle	, maiden	Sumame	9)	
E E	ř	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	a Address (Street a			l Route Numb	er City	r Tours	State Zin	Cadal
rtrau		Creed C. Patric		Son						vater,		,, , , , , , , , , , , , , , , , , , ,	31216, 2 <i>1</i> p	0000)
otha		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name	of	Ku. E		valer,		ocation - (City or To	wn, State
30		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	'		Family		1	1-10)_04	۸ 1	1400		77 A
i i i	1	21. Signature of Funeral Service Licer		101		. Name and	Address	of Facility	,		AI	liso	ma,	VA
E # 8		mulu.	Mass	de	\mathcal{M}	Bowe	r F	unera	1 Ch	apels Blvd. P	1	1	57 A O	/ 201
		23a. Part I. Enter the disease or com shock, or heart failure. List only	plications that cause	d the death.	Do not ente	er the mode	of dying	, such as c	ardiac o	r respiratory a	rrest,	K1,	VA Z	Approximate Interval Between
ician		Immediate Cause (Final disease or condition		phe.										Onset and Death
dical		resulting in death)	a. Due to (or as										1	Luceks
iner		Sequentially list conditions.	D	nal	Insu	ffic	1000	4						Syears
Jis .	lue	Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se				115	- 4						11
l-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as		ince of):	MI	((4/	ner						TYPONS
buria	a E		200 (0/ 03	4 00/136446	nee or).									
s the burial-transit	edical		d			_					_			
for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			_						23d. Date	of delive	rv
od for	cla	in the past 12 months? 1 □ Yes 2 DNo	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic preg Other (spec						Mont		Day Year
detached	hys	9 Unknown	9□ Unknown											
be det	by	Part II. Other significant conditions of	ontributing to death b	out not resulti	ing in the un	derlying cau	ise given	n in Part I.		23e. Did to	obacco u	se contrib	oute to th	e cause of death?
should	ted									101	(es 2)	Q No 3	∃ □ Proba	ably 4 Unknow
	Completed									24a. Was	şy	24b. W	ere autop	sy findings available
ral director, page 2									_	perfo	rmed? 2 No		ath?] Yes :	2□ No
ector	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o				
ral di	ပ္	1 Yes 22 No 27. Manner of Death	1 Mipatie		NOutpatient 8b. Time of		Other	4 L Nurs		ne 5 🗌 Resid 8d. Describe h)
fune	t o	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	M	: Injury a Work?	a` es 2.⊟No		au. Describe :	iow injur	y occurred	u	
by the	Certification;	3 Suicide 6 □ Could not be	28e. Place of Inj	ury - At home	e, farm, stre					8f. Location (S	Street and	d Number	or Rural	Route Number,
filled in t	ert	4 Homicide determined	building, et	c. (Specify)		, , , ,				City or Ton	m, State,			
	Medical	29a. Certifier 1 Certifying Ph. (Check only one)	ysician: To the best niner: On the basis of and manner sta	t examinatioi	edge, death n and/or invi	occurred at estigation, in	the time my opir	, date and nion, death	place, a	nd due to the o	cause(s) date and	and mani place, an	ner as sta	ited. the cause(s)
etely fill	0	29b. Signature and title of certifier		2100.		29c. L	icense r	number			29d. Date	signed ((Month, D	lay, Year)
completely fills	Σ∣)			-	10.0				-		
completely fill	Σ	> flance we	con, MIV			DS	28.	50		1	GUIL	WU	1.7-	04
completely fill		Jeluw we	completed cause of d	eath (Item 2)	3a) (Tvne 🖺	Print)			_		KINVO	wy "	1,20	04
ē		Jenum wes 30. Name and address of person who of Jeanne Weyner, Mt. 31. Date filed (Month, Day, Year) 10. 14. 26	completed cause of d	eath (Item 2)	3a) (Type, P	Print)			2		KINVO UYO	01	1,20	04

State of Maryland / Department of Health and Mental Hygiene 2001

0	0	Sec.	3	0
	6.	.7	7	A

		1 - For State Registrar	State of Ma		ertificate of		Re	g. No.		11601
Physic	ian	Decedent's Name (First, Middle, Lass					2. Date of Death Month	Day	Year	3. Time of Death
/Med	ical	GERTRUDE		PEARSON	14. O't. T.	1 1 1 1	JAN.		004	11:50P M
Exam	iner	4a. Facility Name (If not institution, give				or Location of Death		4c. County o		
		7507 MARION S 5. Social Security Number 6. S		(In yrs. last birthda	227	RESTVILLE If Under 24 Hrs.	8. Date of Birth			EORGES
Funera Directo			TM 2VTF	103 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1) JAN. 20,	1900		lace (State or Foreig try) GLAND
show	7	10a. State 10b. County		10c. City, Town or			-		1	Od. Inside City Limit:
the M	Director	MD. PRINCE G	EURGES		FORESTV	ԼևևԷ	10	g. Citizen of W	hat Cour	
with as or		7507 MARION S	T.			747				
death ms 2;	Funerai	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13		Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No-	14. Race	- Americ	ENGDOM an Indian,
within 72 hours after death with the Maryland Jiene "netural", or Items 23s or 28e-f show the Maryland The Ma	by Fur	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes, specify Cub		Hican, etc.)	Specify:	, White,	etc. HITE
2 hou	ted	15. Decedent's Ed	ucation	16a. Dec	edent's Usual Occu	pation	16	6b. Kind of Bus		
hin 7	Completed	(Specify only highest gra	de completed) College (1-4or 5+	life	O NOT use retire	during most of work ad)	ng			
V gob.	Con		2		SECRETARY	Z		SCI	IOOL	
be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
	2			BUCKLE			ATILDA	LEGGO		
d 2 should the and Mer the and Mer treumatic treumatic		19a. Informant's Name/Relationship (7				t and Number or Run				Code)
		JANE MARY BALKCU 20a. Method of Disposition	M/DAUGHTER	7507 20b. Place of Dis	W . W	ST., FORE		MD . 20 0c. Location - 0		um Ctata
permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.	>	1 ☐ Burial 2 【Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		cemetery, cr	ematory or other pla	ice)	-2004	RIVERI		
permit. Departr Importa		21. Signature of Funeral Service Com	11.00	M00091	HAMBERS 1	FUNERAL HO ELAND AVE.	ME & CRE	MATORIU ALE MI	M,P.	A. 1737
		23a. Part1. Enter the disease, or comp	plications that caused to	he death. Do not e					- 20	Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final			A GE					Interval Between Onset and Death
/Medica	_	disease or condition resulting in death)	w	ER S DISI consequence of):	EASE					
Examiner			HYPERCI							
	je l	Sequentially list conditions, if any, leading to immediate cause. Litter Universitying	0.	consequence of):						
ou, be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c							
e exe		resulting in death) Last	Due to (or as a	consequence of):						
do f do, rificate be executed rg physician and as the burial-transit	Aedical		d							
	Mec	IF FEMALE:	20. 11						1	
at the death cert by the attending	Physician/A	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ZXNo 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date Mont		ry Day Year
that the ed by detain		Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause gr	ven in Part !.	23e. Did toba	icco use contrit	oute to th	e cause of death?
uires t uires t signe	d by	HYPOTHYRO11	•				1 🗆 Yes	2 X No 3	Prob	ably 4 Dunknown
The law requires that the the has been signed by the page 2 should be detached.	Completed						24a. Was an autopsy	pr	ere autor or to con ath?	osy findings available
	S						performe 1 ☐ Yes 2	X No 1	Yes	2 🗆 No
Physician: T this certificate ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		_ Oti	26. Place of Death			-	-
5 £ ± 5	1.	1 ☐ Yes 2 😿 No 27. Manner of Death	1 Linpatieni	t 2 ☐ ER/Outpati 28b. Time	MIL SON	4 Li Norsing Flo	me 5 x Residen 28d. Describe how			")
fe fe	ţ	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) Injury	Wo	rk?]Yes 2 □No	200. 20000000 11011	injury occurre	•	
al or Attending s after death.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	-	y - At home, farm, s (Specify)			28f. Location (Stre City or Town,		or Rura	Route Number,
spita ours neral		29a. Certifier 1 Certifying Ph	ysiclen: To the best of liner: On the basis of e	my knowledge, de	ath occurred at the ti	me, date and place,	and due to the cau	ise(s) and man	ner as sta	ated.
To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of certifier	and manner state	ed.	29c. Licen			d. Date signed		
		10000 A-		D	n:	21925		JAN. 9	. 20	004
13		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type				V.11110	, 20	
			INS, M.D.		,	NIA AVE. #	106. UPP	ER MART	BORO	.MD.20772
S	tate	31. Date filed (Month, Day, Year)	32. Pegistrar		-					,
Regis	trar	JAN 12 20	U4 Sener		spark.	2				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dean William Penner Suburban Bospital Suburban Bospital Suburban Bospital Dean Grant description, power attend and number) Social Security Numbers Social Securi					State of Ivial	ylanu / L	Certificate o		and Mentar	Reg. No		025 9
Deam William Penner Penn		S 1 · ·		1. Decedent's Name (First, Middle, Last)		-				of Death		3. Time of Death
Security Nation (First Annual Classification) Suburbanian (Fir	40			Dean William	Penne	r_						
Social Sourcety Number 6. Sec. 12 Age Payrs. Last pirms(ally 1. Under 11 types 1. Under 24 types										Death 4c	. County of De	ath
Standard										1		
Total Tota				543-32-6526	M 2□F		Months Da		Min. (Monti	of Birth n, Day, Year, 13, 1	931 Ore	irthplace (State or Foreign Country) egon
Elementary/Secondary (0-12) Codege (1-4or 5+) Communication Specialist Defense Industry	rland	A 14			1	IOc. City, Tow	n or Location					10d. Inside City Limits
Demonstray Secondary Go-12 College (1-4or 5+) Communication Specialist Defense Industry	Σ	- 3	ģ	Maryland Montgome	ry	Germa	ntown					1 ☐ Yes 2X No
Demonstray Secondary Go-12 College (1-4or 5+) Communication Specialist Defense Industry	Ť Ť	22 2	Ž	10e. Street and Number			10f. Zip Cod	le		10g. Ci	tizen of What C	Country?
Demonstray Secondary Go-12 College (1-4or 5+) Communication Specialist Defense Industry	ŧ.	8 g		12123 Red Admira	1 Way		20	876		Uni	ted Sta	ates
Elementary/Secondary (0-12) Codege (1-4or 5+) Communication Specialist Defense Industry	020 ours efter dee	rai', or itema Examiner m	by Fune	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 No If Yes, Give	1953 - 1955	1 □ Yes 2 🛣 I	No Specify:		r No-)	Black, Wh	ite, etc.
200. Method of Disposition (Disposition (Dis	2 2		e e	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	Decedent's Usual Oc (Give kind of work do	cupation ne during most	of working	16b. K	(ind ot Busines	s/Industry
20a. Method of Disposition 1	121 if	. c .	ם	Elementary/Secondary (0-12)		1				D 5	-	1 .
20a. Method of Disposition 1	0 P	her t		17 Father's Name (First Middle Last)	4	Cc	ommunicatio	-				idustry
20a. Method of Disposition 1	and b	ਜ਼ ੇ ≥	9								i Sumame)	
200. Method of Disposition (Disposition (Dis	Shoul Shoul	mark matter	ř	· · · · · · · · · · · · · · · · · · ·	oe. Print)	19b	. Meiling Address (Str			-	or Town. State.	Zip Code)
Description of Spinsterion Service Liopesee 21. Signature of Epideral Service Liopesee 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Deer Park Dr. Gaithersburg, MD 20877 25. Signature of Epideral Service Liopesee 26. Place Park Dr. Gaithersburg, MD 20877 28. Part I. Ember the disagrate. Or complications in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 25. Name and Address of Facility 26. Deer Park Dr. Gaithersburg, MD 20877 26. Place Park Dr. Gaithersburg, MD 20877 27. Name and Address of Facility 28. Part I. Ember the disagrate. Or complications in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 28. Part I. Ember the disagrate. Or complications in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 28. Part I. Ember the disagrate. Or complications in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 28. Anneurysm 29. Due to (or as a consequence of): 29. Due to (or as a consequence of): 29. Due to (or as a consequence of): 29. Anneurysm 29. Due to (or as a consequence of): 29. Due to (or as a consequence of): 20. Due to (or as a consequence of): 21. Yes 20 No 3 Probably 4 Due to (or as a consequence of): 22. Was an autopsy performed? 22. Was an autopsy performed? 22. Was an autopsy performed? 23. Was an autopsy performed? 24. Was an autopsy performed? 25. Was case referred to medical examined? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury A thome, farm, street, factor, office 28. Date of Injury A thome, farm, street, factor, office 28. Location (Street and Number or Rural Rouse Number of Rural Rouse Nu		27 to										
Description of Spinsterion Service Liopesee 21. Signature of Epideral Service Liopesee 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Deer Park Dr. Gaithersburg, MD 20877 25. Signature of Epideral Service Liopesee 26. Place Park Dr. Gaithersburg, MD 20877 28. Part I. Ember the disagrate. Or complications in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 25. Name and Address of Facility 26. Deer Park Dr. Gaithersburg, MD 20877 26. Place Park Dr. Gaithersburg, MD 20877 27. Name and Address of Facility 28. Part I. Ember the disagrate. Or complications in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 28. Part I. Ember the disagrate. Or complications in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 28. Part I. Ember the disagrate. Or complications in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 28. Anneurysm 29. Due to (or as a consequence of): 29. Due to (or as a consequence of): 29. Due to (or as a consequence of): 29. Anneurysm 29. Due to (or as a consequence of): 29. Due to (or as a consequence of): 20. Due to (or as a consequence of): 21. Yes 20 No 3 Probably 4 Due to (or as a consequence of): 22. Was an autopsy performed? 22. Was an autopsy performed? 22. Was an autopsy performed? 23. Was an autopsy performed? 24. Was an autopsy performed? 25. Was case referred to medical examined? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury A thome, farm, street, factor, office 28. Date of Injury A thome, farm, street, factor, office 28. Location (Street and Number or Rural Rouse Number of Rural Rouse Nu		er ate		20a. Method of Disposition					Date	20c. Le		
Physician Madical Examiner 10 E. Deer Park Dr. Gaithersburg, MD 20877 10 E. Deer Park Dr. Gaithersburg, M	itimo	ntment: if		4 ☐ Donalion 5 ☐ Other (Specify)	smoval from State		ouls Cemete	ery	2004	Ger		n, Maryland
Physician Medical Examiner Medical Examiner Me	6 8	on impo			W	٦			Devol F			D 20877
Medical Examiner Medical Exa			\neg	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line.	e death. Do r	not enter the mode of	dying, such as o	cardiac or respirato	ry arrest,		Approximate Interval Between
Subarachnold Hemorrhage 2 Monte of the substituting in death) Sequentially list conditions, if arry, leading to immediate the substituting in death) Last Sequentially list conditions, if arry, leading to immediate the substituting in death) Last Sequentially list conditions, if arry, leading to immediate the substituting in death) Last Due to (or as a consequence of): Due				V /								Onset and Death
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause given in Part I.				disease or condition	Subarach	noid H	emorrhage					2 Months
A Ortic Valve Replacement Composition of the com			ě		Du	ue to (or as a d	consequence of):					1
Aortic Valve Replacement Compose	pet	nsit	틭	b.								Years
A Ortic Valve Replacement Composition of the com), exec	n and lai-tra	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Du	ie to (or as a c	consequence or):					
A Ortic Valve Replacement Composition of the com	76(te be	ysicia 10 bul	8	Cause (Disease or injury that initiated events	Du	e to (or as e c	onsequence of):					
24a. Was an autopsy fir available prior to completion of card death? 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred		O 60	_									
24a. Was an autopsy fir available prior to completion of card death? 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	B	d for		Part II. Other significant conditions cont	ributing to death but r	not resulting in	the underlying cause	given in Part I	23h	Did tobacco	use contribut	e to the cause of death?
24a. Was an autopsy fir available prior to completion of card death? 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	O §	by the	2		-	iot rooditing iii	and andonying daddo	groom arr arr i.	13	_		
24a. Was an autopsy fir available prior to completion of card death? 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	S, F	pe ec	2	AOILIC VAIVE RE	ртасешенс				_			,
Second S	SCORD BW require	been s should	pleted						24a. \	Vas an autoperformed?	psy 24b.	Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner? Composition ۾ ڪ	pege h	팃						1 4	□Yes 2	K No	1 ☐ Yes 2 ☐ No	
No Hospital: 1 Image I		ortific octor,		examiner?				The state of the s	of Death (Check of	nly one)		
27. Manner of Death 1 Di Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 4 Work? 1 Yes 2 No 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Location (Street and Number or Rural Route Numb City or Town, State) 28d. Describe how injury occurred		his ce	임	1 ☐ Yes 2 No	1 LA Inpatient		patient 3LI DOA	4 LI Nur	sing Home 5 🗆 F	Residence	6 □Other (Spe	ecify)
So S	ion o	eth. r: After ti ie funere	atlon	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. T				ibe how injur	ry occurred	
29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Divis	offer de Directo		dataminad	28e. Place of Injury building, etc. (- At home, far Specify)	m, street, factory, offic	Ce .				lural Route Number,
	Hospita	24 hours Funeral etely filler	dical C	(Check only 2 Medical Examine	er: On the basis of ex	amination and	death occurred at the Vor investigation, in m	time, date and y opinion, death	place, and due to n occurred at the til	the cause(s) ne, date and	and manner a d place, and du	s stated. e to the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	o the	Vithin Sompi	Σ	29b. Signature and title of certifier			29c. Lice	anse number		29d. Dat	te signed (Mon	th, Day, Year)
70+1 P. Celwar, M.D. D36552 January 11, 2004				1 Cel	Jan, Mis		03	6552		Janı	uarv 11	. 2004
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)		V				-		Vi 191-10		0 0.11	,	
Pankaj Talwar, M.D. 50 W. Edmonston Dr. #401 Rockville, Maryland 20852			1					401 R	ockville,	Mary:	land 20	852
State 31. Date filed (Month, Day, Year) AN 1 4 2004 Security Signature State State Aparks					32. Registrar's		5 Spar	the state of the s				

PENNER, DEAN.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** William L. Pierce 13, 2004 January 6:45 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1√ M 2□ F June 10 Months Days Hours 67 Nebraska Director 507-36-1741 the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28e-f show Maryland Montgomery Chevy Chase 11 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4515 Willard Avenue Apt. 2110 20815 United States death or Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Exeminer Black, White, etc. filed within 72 hours after 1 Never Married Married Maryland 21215-0036 White 1 ☐ Yes 2X No by Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 5+Child Welfare Adoption . Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If Item 27 is marked other taury, ar other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Hugh Pierce Agatha Patricia Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula S. O'Connor/ Wife 4515 Willard Ave. Apt. 2110, Chevy Chase, MD 20815 Baltimore, Ceo. Wash. University

Medical Center

20b. Place of Disposition (Name of cometery, crematory or other place)

January 13

Geo. Wash. University

Medical Center 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Columbia Mortuary Services, Inc.
P.O. Box 58007 Washington, D.C. 21 Monature M/Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Prostate Carcinoma Years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Tue to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medicai as use IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) signed by the a o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ cate has been signated by page 2 should b 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? certificate 1 ☐ Yes 2 🙀 No of Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospice 1 ☐ Yes 2 🄀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the Director 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 50 within 24 hours after To the Funeral Dire To the Hospital 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D35635 January 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. Kaplan, M.D. 6001 Muncaster Mill Rd. Rockville, MD 31. Date filed (Month, Day, Year)

JAN 14 2004 32. 🚁 jistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Honth + JANSON CHRISTORNER PINTO **Physician** Day i S 2004 7010 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTFONERY BEWELL HOSPITAL OUNEY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign Country) 1⊠M 2□ F Yrs. 577-88-0184 Director 39 <u>January</u> 8, 1965 Tanzania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-i show amy injury or other traumatic event, the Medical Evanine must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Rockville Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4703 Lance Court 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Asian <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Network Engineer Computer Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe Simeon Victor Pinto Amancia Olinda D'Souza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Marie Pinto/ Wife 4703 Lance Court, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State January 17 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2004 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 2090 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOVASCULAR DISEAS ARTERIOSCUROTIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be HTERTOUSIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 No 1 ☐ Yes 2 🗆 No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DME 015236 JANUARY 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IIIS ROCKVILLE PIKE, ROCKILLE, MO 20852 CARL I. MARROUIS, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mary Frances Plaza 2004 11:30 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15526 Prince Frederick Way Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🕱 F 84 Yrs May 27. Director 352-01-9724 Ireland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show notified at 1 ☐ Yes 2 T No Maryland Montgomery Silver Spring Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 2 15526 Prince Frederick Way 20906 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status odical Exerciner filed within 72 hours after 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 Widowed 4 Divorced nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Direct Mail The Ms rthan Elementary/Secondary (0-12) College (1-4or 5+) Production Manager Advertising nrmit. Pages 1 and 2 should be filed wi spartment of Health and Mental Hygien portant: If item 27 is marked other th y injury opather treumatic event, Ites ics. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Byrne Mary Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14510 Faraday Drive, Rockville, Maryland 20853 Patricia Heeney/Daughter 20b. Place of Disposition (Name of commetery, crematory or other place)
Gate of Heaven
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition January 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Ave., Rockville, MD 20850-2805 any in M00198 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Immediate Myocardial Infarction /Medical Due to (or as a consequence of): **Examiner** Arteriosclerotic Heart Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Years Hypertension physicien ar s the burial-ti Due to (or as a consequence of) Box 68760. Physician/Medical as t IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown à signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 3 Probably 4 □Unknown 1 ☐ Yes 2 ☑ No should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page certificate 2**X** No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1X Yes 2 □ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours after To the Funeral Dire 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W D23958 January 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Burt Ira Feldman, M.D.

JAN 12 2004

31. Date filed (Month, Day, Year)

souks

32. Registrar's Signature

3305 North Leisure World Blvd., Silver Spring, Maryland 20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JAMMÜARY ™2,2ÖTG4 6:22P.M PROPTS **Physician** WILLIAM WINDSOR /Medical 4c. County of Death
Montgomery 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Takoma Park Examiner Washington Adventist Hospital Months Days Hours Min. March 19, 1919 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland 1 **X**M 2 □ F 84 Director 578-38-9675 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla. nent of Health and Mental Hygiene. and it is them 23e or 28e-1 show and it if it is not 2 is marked other then 'natural', or items 23e or 28e-1 show ury or other traumatic event, if a healtest Examinat must be rutilled it. 1 Yes 2 No Prince GEorge's Beltsville Maryland Directo 10f. Zip Code 20705 10g. Citizen of What Country? United States 10e. Street and Number 4411 Yucca Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X(1)Yes 2 □ No If Yes, Give WWII Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 2 Electrical Engineering Specialist 18. Mother's Name (First, Middle, Maiden Sumame) Mary Margaret Yingling 17. Father's Name (First, Middle, Last) Be Carl Reihl Propts 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4411 Yucca Street Beltsville, Maryland 20705 Katharine M. Propts -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/13/2004 | Alexandria, Virginia 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, P.A. mald 4400 Powder Mill Rd. Beltsville, Maryland 20705 12 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a Examiner anding physicien and use as the buriat-transit The law requires that the death certificate be executed Due to (or Physiclan/Medlcal signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Winknown 1 ☐ Yes 2 ☐ No should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? 1 ☐ Yes 20 No certificate 1 ☐ Yes 2 1 No To the Hospital or Attending Physician: Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 No Mpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 2 ER/Outpatient 3□ DOA After this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
JAN 16 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Nasreen Kango, M.D. 7610 Carroll Avenue Takoma Park, Maryland 20912

32. Registrar's Signature

29c. License number 5614

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Mabel Pugliese 10:15 PM January 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 213-54-7315 94 Director March 20, 1909 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ahow the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 303 Adclare Street 20851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 2 3 Widowed 4 Divorced Year or Dates natural Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Demostine DeDominicas Assunta Soliimeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodora W. Pugliese/Wife 14507 Kelmscot Dr., Silver Spring, MD 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery January 13 * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 2004 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Molley 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis resulting in death) /Medical Due to (or as a consequence of): Examiner <u>Abdominal Pain</u> Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transit Back Pain Due to (or as a consequence of): Box 68760 attending physiciar Physician/Medical Chronic Urinary Tract Infections as the IF FEMALE use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? Day Year 5 Other (specify) P.O. 1 the ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by (Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ②XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attand within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D43272 January 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Right) 1201 Seven Locks Road, Suite 111, Rockville, MD 20854 Dr. Sunita Hanjura 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 13 2004 Registrar oaken

			1 - For State Registrar	State of Mary		artment of rtificate of		Reg	ene 200	4 02525
	Physici /Medic	200	1. Decedent's Name (First, Middle, Last Lillian	Mae	Qui	mby		2. Date of Death Month January	9 ^{Day} 2004 ^{Yea}	3. Time of Death 1:00AM M
	Examir		4a. Facility Name (If not institution, give Washington Adventi	st Hospital		Takoma			4c. County of De Montgom	ery
d)s	Funeral Director		5. Social Security Number 6. Se 214-84-2760	x 7. Age (In 82 82	yrs. last birthday) Yrs.	If Under 1 Yea Months Days			^(9ar) , 1921 No	Birthplace (State or Foreign County) Orth Carolina
	ith the Maryland or 28a-f show	ctor	10a. State 10b. County Maryland Montgome		c. City, Town or Lo Silver S					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with th	Funeral Director	10e. Street and Number 10809 Amherst Ave	enue #A		10f. Zip Code 20902			g. Citizen of What Inited St	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitant must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ No		Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, hite, etc. Thite
21215-0036	I within 72 ho lene. r then "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life. Homen		upation e during most of wo ed)	orking	Own Home	
Maryland 2	buid be filed Mental Hyg arked other atic event,	To Be C	occupii —	estes			18. Mother's Na Minnie	me (First, Middle, Ma E .	Byrd	
, Mar	and 2 sho lath and 127 is m or traum		19a. Informant's Name/Relationship (7) Brent Quimby (5)	Son)	lA l Gett	Bonnie Fi Lysburg,	ield Circ PA 173	lural Route Number, C 1e 25	City or Town, State	, Zip Code)
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □F 1 □ Donation 5 □ Other (Specify)	Tellioval Itolii State	Ob. Place of Dispo cemetery, crea Chesapea	osition (Name of matory or other pl ake Crema	ace) atory Jan.		c.Location-City	
Balt	permit. Depart Import any inj		21. Signature of Furrieral Service Licens	Frody M	026/ 19.	2. Name and Add app Fune: 33 Gist	ress of Facility ral And C Avenue S1	remation S lver Sprin	Services	10910
	Physician /Medical Examiner		23a. Part1. En or the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications tha Sused the ne cause of each line. a	aten	ter the mode of dy	()	c or respiratory arrest		Approximate Interval Between Onset and Death
	icate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
68760,	ificate be e g physiciar as the buri	Ical		d		-				
.O. Box	es that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal déath 3 [Ectopic pregnan Other (specify)	су		23d. Date of o	delivery Day Year
rds, P	law requires that as been signed t 2 should be deta	þ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause g	iven in Part I.	23e. Did tobad	V	to the cause of death? Probably 4 DUnknown
il Records,	The ate ha	Completed						24a. Was an autopsy performe 1 Yes 2	24b. Were prior to death'	
of Vital	Physician: r this certificated fral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatier	nt 3□ DOA O	thac	ath (Check only one)	e 6 ⊡Other (St	pecify)
Division of	Attending Phr r death. sctor: After thi by the funeral		27. Manner of Death 1 XNatural 5 Pending investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o Injury	W	The second secon	28d. Describe how		,
Divis		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	pecify)			City or Town, S	State)	Rural Route Number,
	the Hospital or thin 24 hours after the Funeral Dir mpletely filled in	Medical	29a. Certifier (Chee by 2 Medical Examione) 29b. Signature and title of certifier	sician: To the best of maner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	vestigation, in my	time, date and place opinion, death occurs on number	urred at the time, date	se(s) and manner and place, and d . Date signed (Mo.	ue to the cause(s)
	S with		David C	vome	eoul)	1	1038	35 J	anvar	y 9, 2004
	(10	30. Name and address of pers in who or \$\frac{3}{2} \rightarrow \text{VN} \rightarrow \text{US}, \$\frac{1}{2} \text{31. Date filed (Month, Day, Year)}	ompleted cause of death	rord	Print) DAY	51/10	15 prin	5 mar	y/im/
	Sta		IAN 1 2 200	1 Separa	y	Spark	2/		/	1

	<		1 - State Registrar AMEND ITEM #1	1 PER INF G828 2/10	/Certifica	te of Dea	th and Ment ath	al Hygien Reg. N	7 1 14	02526
Н	Physici	200	Decedent's Name (First, Middle, Last)			2. Da	ate of Death onth Da	ay Year	3. Time of Death
П	/Medi		Belur Premalatha	Radhakrishnan					2004	4:07 A M
	Examir	er	4e. Fecility Name (If not institution, give	street and number)	4b. City	, Town, or Loca	tion of Death	40	. County of Deeth	
			Suburban Hospital			hesda			Montgomer	
¢	Funeral		5. Social Security Number 6. Se	TM 2005	Months		nder 24 Hrs. 8, Da urs Min. (M	ate of Birth Ionth, Day, Year	9. Birth	place (State or Foreign intry)
To	Director		3/1-44-34/4	^{2™ 2} X ^r 71	Yrs.		0c1	t. 27, 1	932 Indi	a
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City. To	own or Location					10d. Inside City Limits
	faryt.	ò								1 ☐ Yes 2 ☒ No
	28a-1	ect	Maryland Montgome 10e. Street and Number	ry Bet	hesda	- 0 - 1 -		10-0	25	
	with pe	늅			101. 21	p Code	_		tizen of What Cou	
	s 23	rai	9202 Kirkdale Road		140.111	2081			ited Stat	
	ltam Itam	Š	11. Marital Status 1 ☐ Never Married XXX Married	12. Was Decedent Ever in U.S. Armed Forces?	If Yes, spe	ecify Cuban, Me	c Origin? (Specify Y xican, Puerto Rican,	es or No-	 Race - Ameri Black, White 	
36	rs af	ρ	3 Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	1 🗆 Yes	2 No Spe	ecify:		Specify: Asia	an Indian
ş	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show ha Madical Examiner Lists be netified at	Completed by Funeral Director	15. Decedent's Edu		Sa. Decedent's Usu	al Occupation		16b k	(ind of Business/Ir	dusta
15	in 72	olet	(Specify only highest grad	e completed)	(Give kind of wi	ork done during use retired)	most of working	100.1	Circle of Desiriosari	idustry
21215-0036	iene iene tha	E	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	omemaker			Orar	Home	
O	Hyg Hyg other		17. Father's Name (First, Middle, Last)		omemaker	18. N	Nother's Name (First			
au	ld be ental ked c	To Be	C.R. Iyengar			Ana	anda Belui	r		
2	shoul nd M	1	19a. tnformant's Name/Relationship (T)	rpe. Print)	9b. Mailing Addres		umber or Rural Rout		or Town State Zi	n Code)
Maryland	id 2 s						Potomac, N			0 0000)
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show among injury or other traumatic event, the Macical Examiner mark by notified at ance.		Badri Belur Radhak 20a. Method of Disposition	20b. Place	of Disposition (Na	me of	Date		ocation - City or T	own. State
<u></u>	nt of nt of the state of the st		1 Bunal 2 Cremation 3 F	Monte	tery, crematory or one ry		January	16,	í	
Baltimore,	ning and a		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 	Crema	toriūm.]	[nc.	2004	Bet	hesda, M	aryland
Ba	Department of the position of		21. Signature of Fullerial Service Eldens	M012	Bethes	da-Chev	y Chase,	Inc. 75	phrey Ful 57 Wiscon	neral Home/ nsin Avenue
			On Part Friends disease average	MU134	Bethes	da, Mar	yland 208	14-3501		
Е			23a. Pert1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.	o not enter the mo	de of dying, suc	n as cardiac or respi	iratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Metastatic Re	enal Cano	er				6 Months
Ш	/Medical Examiner		resulting in death)	Due to (or as a consequenc	e of):					
ĝ	LAGIIIIICI	_	Sequentially list conditions,).	-7/4					
	be sit	Examiner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying	Dua to (or as a sunsaquene	e of).					
	and tran	аш	Cause (Disease or injury that initiated events resulting in death) Last	b						
760,	icate be executed physician and s the burial-transit			Due to (or as a consequenc	e or):					
200	ate t hysic the b	lical		j						
200	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE:	10-20-20-20-20-20-20-20-20-20-20-20-20-20						
Rox	ith ce	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea	th 3 Ectopic p	regnancy		1	23d. Date of deliv	•
	he al	sici	1 ☐ Yes 2 X No	4☐ Pregnant at time of death 9☐ Unknown	5 Other (s	pecify)			Month	Day Year
٦.	that the de led by the a detached f	Phy	9 Unknown			-				
	es th ignec	by	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying o	ause given in F	art I. 23	3e. Did tobacco	use contribute to t	he cause of death?
ğ	w requires to been signer should be a	ted						1 Tes 2	∑ No 3□Prot	ably 4 Unknown
Records,	aw re	Completed					24	la. Was an	24b. Were auto	psy findings available
w	The lav	E						autopsy performed?	death?	mpletion of cause of
ľ			25 W			26 F	Place of Death (Chec	Yes 2∏ No	1 Tes	2 140
tal	an: tific tor.	a	25. Was case referred to medical			Other			6 □Other (Specif	-
Vital	ysician: Th is certificate director, pag	Φ.	examiner?	lospital: 1 X Inpatient 2 ☐ ER/C	Outpatient 3 Do	Other: 4	I Nursing Home 5			(v)
Vital	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of Injury 28b	Outpatient 3 Do	JA 4	Nursing Home 5 28d. De	escribe how inju		y)
Vital	Physician: this certific ral director.	To B	examiner? 1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending	1 Minpatient 2 LER/C		28c. Injury at Work?	28d. De			y)
Vital	Ntending Physician: death. ctor: After this certific y the funeral director.	To B	examiner? 1	28a. Date of Injury (Month, Day Year) 28b. Place of Injury · At home,	. Time of Injury M	28c. Injury at Work?	28d. De 28f. Lo	escribe how inju	ry occurred ad Number or Rura	
Vital	*Attending Physician: or death. rector: After this certific by the funeral director.	To B	examiner? 1 Yes 2 Xo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b	. Time of Injury M	28c. Injury at Work?	28d. De 28f. Lo	escribe how inju	ry occurred ad Number or Rura	
Vital	*Attending Physician: or death. rector: After this certific by the funeral director.	Certification; To B	examiner? 1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, building, etc. (Specify)	Time of Injury M farm, street, factor	28c. Injury at Work? 1 — Yes y, office	28d. Do 2 No 28f. Lo Cit	escribe how inju cation (Street ar by or Town, State	ry occurred and Number or Rura and manner as s	al Route Number,
Vital	r Hospital or Attending Physician: 24 hours atter death. Funeral Director: After this certific sely filled in by the funeral director.	Certification; To B	examiner? 1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Place of Injury · At home,	Time of Injury M farm, street, factor	28c. Injury at Work? 1 □ Yes y, office	28d. Do 2 No 28f. Lo Cit	escribe how inju cation (Street ar by or Town, State	ry occurred and Number or Rura and manner as s	al Route Number,
Vital	r Hospital or Attending Physician: 24 hours atter death. Funeral Director: After this certific sely filled in by the funeral director.	To B	examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Place of Injury · At home, building, etc. (Specify) sicien: To the best of my knowled.	Time of Injury M farm, street, factor ge, death occurred	28c. Injury at Work? 1 □ Yes y, office	28d. Do 28f. Lo Cit e and place, and dudeath occurred at the	escribe how inju cation (Street ar by or Town, State e to the cause(s he time, date and	ry occurred and Number or Rura b)	al Route Number, lated. b the cause(s)
Vital	Ntending Physician: death. ctor: After this certific y the funeral director.	edical Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	28a. Date of Injury (Month, Day Year) 28b. Place of Injury · At home, building, etc. (Specify) sicien: To the best of my knowled.	Time of Injury M farm, street, factor ge, death occurred and/or investigation 29	28c. Injury at Work? 1 Yes y, office at the time, dat i, in my opinion,	28d. Do 28f. Lo Cit e and place, and dudeath occurred at the	cation (Street ar y or Town, State e to the cause(s ne time, date and	nd Number or Rura and manner as s d place, and due to	al Route Number, lated. b the cause(s) Dey, Year)
Vital	r Hospital or Attending Physician: 24 hours atter death. Funeral Director: After this certific sely filled in by the funeral director.	edical Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injury (Month, Day Year) 28e. Place of Injury · At home, building, etc. (Specify) sicien: To the best of my knowledings: On the basis of examination a anamagner stated.	Time of Injury M M farm, street, factor ge, death occurred and/or investigation D	28c. Injury at Work? 1 Tyes y, office at the time, dat i, in my opinion.	28d. Do 28f. Lo Cit e and place, and dudeath occurred at the	cation (Street ar y or Town, State e to the cause(s ne time, date and	nd Number or Rura a) and manner as s d place, and due to	al Route Number, lated. b the cause(s) Dey, Year)
Vital	r Hospital or Attending Physician: 24 hours atter death. Funeral Director: After this certific sely filled in by the funeral director.	edical Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and tilde of certifier 30. Name and address of person who	28a. Date of Injury (Month, Day Year) 28b. Place of Injury · At home, building, etc. (Specify) sicien: To the best of my knowledings: On the basis of examination a and margner stated.	Time of Injury M farm, street, factor ge, death occurred and/or investigation D (Type, Print)	28c. Injury at Work? 1 Tyes y, office at the time, dai , in my opinion, c. License numl	28d. Do 28f. Lo Cit e and place, and dudeath occurred at the	cation (Street ar by or Town, State e to the cause(s) te time, date and 29d. Da Janua	ny occurred and Number or Rura and manner as s d place, and due to te signed (Month, ary 15, 2	al Route Number, lated. b the cause(s) Dey, Year)
Division of Vital R	r Hospital or Attending Physician: 24 hours atter death. Funeral Director: After this certific sely filled in by the funeral director.	Medical Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injury (Month, Day Year) 28b. Place of Injury · At home, building, etc. (Specify) sicien: To the best of my knowledings: On the basis of examination a and margner stated.	Time of Injury M farm, street, factor ge, death occurred and/or investigation 29 D) (Type, Print)	28c. Injury at Work? 1 Tyes y, office at the time, dai , in my opinion, c. License numl	28d. Do 28f. Lo Cit e and place, and dudeath occurred at the	cation (Street ar by or Town, State e to the cause(s) te time, date and 29d. Da Janua	ny occurred and Number or Rura and manner as s d place, and due to te signed (Month, ary 15, 2	al Route Number, lated. b the cause(s) Dey, Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dev Year Physician MARIAN **ESTHER** RANERE JANUARY 13, 2004 10:30A.M /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecitity Neme (If not institution, give street end number) Examiner Hillhaven Assisted Living Nursing & Rehab Center Adelphi. Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, March8, 1918 7. Age (In yrs. lest birthday) 5. Sociel Security Number 9. Birthplace (State or Foreign **Funeral** Hours Deys Months 1 ☐ M 2 🖫 F Washington 338-14-2173 85 Director Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after daath with the Maryland nent of Heatth and Mentel Hygiena. Int: if Item 27 is marked other than "natural", or Items 23a or 28e-f show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a Stete 10b County 1 ☐ Yes 2 No Maryland Prince George's Adelphi Directo 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code ir than "natural", or items 23s or the Medical Exeminer must be 20783 United States 3210 Powder Mill Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 2 3 ₩idowed 4 Divorced Year or Detes: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) 1-4 Elementery/Secondary (0-12) Teacher Education 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be James Price Cora Matheny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Health Item 27 i Renita Ranere Parker -Daughter 11971 Beltsville Drive Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of Important: if Is any injury or o 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/14/2004 Alexandria, Virginia 22. Name and Address of Facility
Donald V. Borywardt Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Cerebral Vascular Accident Examiner Due to (or as a consequence of): Hypertension Examiner Attending Physician: The lew requires that the death certificate be executed attending physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed d be dat Division of Vital Records, á 24b. Were autopsy findings available prior to completion of cause of death? certificate has been si ractor, page 2 should t 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 TY65 25. Was case referred to medical examiner? diractor. Be (26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. tnjury at Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Deeth 28d. Describe how injury occurred Neturel 1 ☐ Yes 2 ☐ No aftar death. Director: Af investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 - Homicide 24 hours aftar • Funerai Dire iletaly filled in b 6 Hospitai 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai within 24 ho To the Fune completaly f (Check only one) end menner stated. To the 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 29c. License number January 14, 2004 0053337 completed cause of deeth (Item 23e) (Type, Print) 30. Name end eddress of person who 10801 Lockwood Drive, 205 Silver Spring, Maryland 20901 Dorothy Sey, M.D. 32. Registrer's Signature 31. Date filed (Month, Dey, Yeer) 'State JAN 1 6 2004 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of <i>rtificate o</i>			lental H	ygiene Reg. No.	1004	02529
	Physic	an	Decedent's Name (First, Middle, Las))			_		2. Date of D Month	eath Day	Year	3. Time of Death
	/Medi	cal	Ann H. Rethinger 4a. Fecility Name (If not institution, give			45 O'S T.			Januar	y 12,	2004	2:05 P ^M
	Examir	ner	Bartholomew House	street and number)		4b. City, Town Bethes		or Death			ounty of Death ontgome:	K22
2	Funeral	à	Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Ye	ar If Unde	r 24 Hrs.	8. Date of B (Month, D		9. Birth	place (State or Foreign
	Director		300-01-0741	_М 2 🔀 F	91 Yrs.	Months Day	/s Hours	Min.	Sept. 2	27, Year) 27, 1912	2 Phil	ntry) ippines
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation						10d. Inside City Limits
	Maryl f sho	Ď	Maryland Montgome	ry	Bethesda							1 ☐ Yes 21∑ No
	r 28a	irec	10e. Street and Number			10f. Zip Code)			10g. Citize	n of What Cou	ntry?
	th with	alD	6904 River Road			2081	7			Unite	d State	es
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show shown you'ng to other traumatic event, the Medical Examinat must be notified at ance.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	Was Decedent of the Yes, specify Control of Yes 2 № N	uban, Mexica	ın, Puerto	ecify Yes or N Rican, etc.)		Race - Americ Black, White, pecify: Whit	etc.
20	72 ho	Completed	15. Decedent's Edi	ication	16a. Dece	dent's Usual Occ	upation				of Business/In	
21	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5-	F)	kind of work dor DO NOT use reti		St of Worki	ng			
2	led w tygier her th	Cor	- 17 Fathada Nama (Fina Adidda (1991)	4	Vice	Presid				Bank		
Maryland 21215-0036	d be findal Hed of	Be	17. Father's Name (First, Middle, Last) John Rethins	rer					(First, Middle Fitzge		imame)	
7	shouk od Me mark mati	ဥ	19a. Informant's Name/Relationship (T		19h Mailie	ng Address (Stre					own State Zin	(Cada)
N	s 1 and 2 soft Health are item 27 is other trau		Ellen M. Williams/			rfield .						
ore,	of Hear		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other p	(aca)	D	ate	20c. Local	tion - City or To	
<u><u>E</u></u>	Page nent de ury ou		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Monts Cremator	gomery			ary 14, 2004		aeda M	arvland
Baltimore,	permit. Departi Import sny inj	r 63	21. Signature of Funeral Service lice is	tur M	00689 Be	Name and Add thesda- Bethes	lress of Facili Chevy da, Ma	ykobe Chase rvlar	ert A. e, Inc. nd 2081	Pumph: 7557 4-350	rey Fun Wiscon	eral Home/ sin Avenue
	Pnysician		23a. Part Enter the disease, or comp shock of heart failure. List only of Immediate oduse (Final disease or condition	ne cause on each line	ਜਿੰਭ death. Do not ent ਰੇ.	er the mode of d	ying, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):							
34	Examiner		Sequentially list conditions,	Kidney :								
	ed ssit	line	if any, leading to immediate cause. Enter Underlying Causa (Useasa or kijur)		consequence of):							
_6	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	·	ized Arter	ioscler	osis					
68760,	siciar suciar	dical		4								
_	tificati g phy as the											
.O. Box	at the death certific by the attending p tached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnan Other (specify)				23d	. Date of delive Month	ory Day Year
٥.	The law requires that the site has been signed by the page 2 should be detached.		Part II. Other significant conditions co.	ntributing to death but	not resulting in the ur	nderlying cause g	en in Part I		23e. Did 1	tobacco use	contribute to th	e cause of death?
Records,	quires n sigr	ed by							10	Yes 2⊠N	lo 3 🗆 Prob	ably 4 Unknown
000	aw require s been sig 2 should b	Completed							24a. Was	an 2	4b. Were autor	osy findings available
	The law ate has page 2 s	mo								psy ormed?	prior to cor death?	npletion of cause of
<u> </u>		Bec	25. Was case referred to medical examiner?				26. Place	of Death	1 ☐ Yes (Check only o	2X No	1 🗆 Yes	
<u>></u>	Physician: r this certifica ral director,	Tol	1 ☐ Yes 2 反 No	lospital: 1 🗆 Inpatient		t 3□ DOA O	ther: 4 🗆 Nu	ırsing Hon	ie 5 ☐ Resi	dence 6 🛣	Other (Specify	isted Living
Division of Vital	ing Afte une	iuo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury		ork?		8d. Describe	how injury of	curred	
Sic	or Attending ifter death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injur	At home form at	200]Yes 2 □	-	8 () ((0		_
<u>></u>	tal or Attend s after death al Director: , ad in by the f	Certification:	4 Homicide determined	building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		2	City or To		umber of Rufai	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sicien: To the best of ner: On the basis of e and manner state	my knowledge, death xamination and/or inv ad.	occurred at the estigation, in my	time, date an opinion, dea	d place, a th occurre	nd due to the d at the time,	cause(s) and date and pla	d manner as sta ice, and due to	ated. the cause(s)
	To T To I	Σ	29b. Signature and IIII of certifier	11-	de- m	9c. Licer	ise number			29d. Date si	gned (Month, L	Day, Year)
,	12		1 - 14/8	· Von	W 111	D11	.024			Januar	y 12, 2	2004
			30. Name and add ess person who co				Oh.	C1	3.6		0001-	
	Sta	te	John B. Umhau, M.D 31. Date filed (Month, Day, Year)	32. Registrar		avenue,	Cnevy	Chas	e, Mar	y⊥and	20815	
	Registr		IAN 1 4 200		na by	Spark	2/					

			1 - For State Registrar	State	of Marylan		artment of <i>tificate of</i>		d Mental Hygi	ene2	04	02529
	Physici /Medic		Decedent's Name (First, Middle, La Alan Rockmore	ast)					2. Date of Death Month January	Day	Yeer 4	3. Time of Death 4:30 P
	Examir		4a. Fecility Name (If not institution, gith Hebrew Home of G	reater	Washingt		Roc	or Location of Do			tgome	ery
	Funeral Director		050-05-4092	Sex 1 🛣 M 2 🗆 F	7. Age (In yrs. 89	Yrs.	If Under 1 Yea Months Days		lin. 8. Date of Birth (Month, Day, May 18,	^{Year)} 1914	Coun	lace (State or Foreign try) York
	death with the Maryland ms 23s or 28s-f show finast be notified at	ector	Usual Residence of Decedent 10a. State	mery		y, Town or Lo Chevy (Chase			Cisi		0d. Inside City Limits 1 X Yes 2 No
	eath with the 23e or 3	Funeral Director	8030 Ellingson D		edent Ever in U.	C 12.1		815		USA	vhat Coun	
0000	72 hours after de netural; or item dical Examine	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed F	orces? 2 ☐ No ive		rvas Decedent or fYes, specify Cui I□Yes 2 🛣 No		(Specify Yes or No- lerto Rican, etc.)		k, White, (
0-01717	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23e or 28e-f show amount of the properties of the marked other then not the Madical Examinations in 20 page.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed,	1-4or 5+)	(Give	lent's Usual Occu kind of work done DO NOT use retire	eduring most of ed)	working 1	6b. Kind of Bu		lustry
ylang z	12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "n treumatic event, the Med	To Be Co	17. Father's Name (First, Middle, Las. Harold Rockmore	1)	3		Salesma	18. Mother's f	Name (First, Middle, M Basse1		tail ₉₎	
Mary	and 2 shou ealth and M n 27 is mar		19a. Informant's Name/Relationship Naomi Balto/Daug					t and Number or	Rural Route Number, Chevy Chas			
oanumore,	Pages 1 and the mont of Height		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special Control of Contro	☐Removal from	State	lace of Dispo emetery, cren	sition (Name of natory or other pla	ace)	-	Oc. Location - 0		wn, State
Dall	permit. Departn Importa any inju		21. Signature of Funeral Service Lice	: Wo	mell	11	. Name and Addr .800 New	ess of Facility H Hampshi	ines-Rinal re Ave, Si	di Fune 1ver Sp	eral	Home
	Physician be executed /Medical Examiner superprise the private transit.	edical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to Due to	EPTIC	LED I	A		CENY, LEFT		T	Approximate Interval Between Onset and Death
O. DOX O	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live I	tcome of pregnal birth 2 Fetal nant at time of de lown	death 3 [Ectopic pregnand Other (specify)	ey .		23d. Date Mon		ry Day Year
ָר עָטְיּ	equires that en signed by	by	Part II. Other significant conditions	contributing to d	eath but not result	alting in the un	derlying cause gi	ven in Part I.	23e. Did toba	5 0		e cause of death?
מו חפני	n: The law re ificate has be or, page 2 sho	e Completed	25. Was case referred to medical						5 70	pr adyo de	/ere autoprior to comeath?	esy findings available apletion of cause of 2 No
7 10 10	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours atter death. within 24 hours atter death. To the Funeral Director: Affer this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	atlon; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon		ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4 Nursing	Home 5 Residen 28d. Describe how			
	nital or Atteurs after de ral Directo	Certification;	3 Suicide 6 Could not be determined	289. Place build	of Injury - At hoing, etc. (Specify	·)			28f. Location (Stre City or Town,	State)		,
	the Hosp thin 24 hor the Fune mpletely fi	Medical	29a. Certifier (Check only one) 1 ☐ Certifying ☐ 2 ☐ Medical Example of Certifier	miner: On the b	a bast of my know asis of examinati ner stated.	viedga, daath ion and/or inv	estigation, in my	opinion, death oc	curred at the time, date	e and place, ar	nd due to	the cause(s)
			30. Name and address of person who	De Cui	D ·	23a) /Tuno			D.	Nu A	08	2004
	Sta	ite	31. Date filed (Month, Day, Year)	PATE	Gistrar's Signat	1) - (ure 4	(21.112	Nice	JA 20 52	other	lly	un Le Siz
	Registr		JAN 122	004 A	Jepera	P	poork	2				

			1 - For State Registrar		State of M	aryland		artment <i>rtificate</i>			Mental Hy	giene Reg. No.	20	04	02530
	Physici	an	1. Decedent's Name (·			_			2. Date of De Month	Day		Year	3. Time of Death
	/Media				S-CARLOS		ROJAS		-		Januar	_	2004		7:35 A M
	Examir	ier	4a. Fecility Name (If n							Location of Dea		40.	County	of Death	
	Funeral		5. Social Security Nun	nber 6. S	kins Hospi	cal ge (In yrs. Ia	st birthday)	If Under		imore C	S. A Date of Rig	th		9. Birthol	ace (State or Foreign
п	Funeral Director		224-04-46	575 ¹	M 2□F	60	Yrs.	Months	Days	Hours Mir	Sept I	4,19	43	Coun	ombia SA
	D		Usual Residence of D			142 00									
	anylau shov	5		10b. County	c	Toe. City,	Town or Lo	cation						10	0d. Inside City Limits 1 ☐ Yes 2X No
	the M	Director	Virginia 10e. Street and Numb		rfax			10f. Zip		rfax		10 - Citi		hat Coun	
	with	Ö			O-la Dudas			TOI. ZIP	Code	22021		rog. Citi			•
	death	era	11. Marital Status	o water	Oak Drive	Ever in U.S.	. 13. \	Was Decede	ent of Hi	22031 spanic Origin? (Specify Yes or Norto Rican, etc.))-		ombi - America	
9	after or ther	Ξ	1 Never Married	Married	Armed Forces	? No		fYes, speci						, White, e	
Š	rel', c	1 by	3 ☐ Widowed 4	□Divorced	If Yes, Give Year or Dates:			1LPYes 2	!∟ No	Specify: C	olombian		Specify:		White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "naturel", or tlems 23a or 28e-1 show ant, the Modrel Examirier i dist be incillised at	Completed by Funeral	1 (Specify	5. Decedent's Ed only highest gra	ucation de <i>completed)</i>		16a. Deced (Give	lent's Usual kind of work	l Occupa k done d	ition Juring most of w	orking	16b. Ki	nd of Bus	iness/Ind	ustry
121	within ane. than	g.	Elementary/Second	lary (0-12)	College (1-4or 5	5+)				, nanical Er		M	£		ai na
d 2	filed Hygin Sther ent, 1	ပ္	17. Father's Name (Fi	irst, Middle, Last)		T	ши	bulai			me (First, Middle			actu	LIUS
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23s or 28e-f show other traumatic event, the M. dical Examilitation at	To Be		Carlos	Julio Sos	sa				Joy	rita Roja	s de	Sos	sa	
ary	shou and N s mar	-	19a. Informant's Nam				19b. Mailin	g Address	(Street a		ural Route Numb				Code)
	and 2 palith n 27 i		Marise	ela Soss	a (Wife)						, Fairfax,	Virg	inia '	22031	
ore	Pages 1 ient of He nt: If iter ry or oth		20a. Method of Dispos 1 ☐ Burial 2 🔀		Removal from State	20b. Pla	ice of Dispo metery, cren	sition (Nam natory or oti	e of her place		Date	20c. Lo	cation - C	City or Tov	wn, State
Baltimore,	tment tent: tent:		° 4 ☐ Donation 5	Other (Specify)	Cr	ematio				14/04				<i>T</i> irginia
Ba	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other than any injury of other traumatic event, Item 2006.		21. Signature of Fune	eral Service Licen	Bush		22	. Name and 1102 V	V. Bro	s of Facility Imphy's Fa oad St	alls Church Falls Chur	Fune	ral H	lome ia 220	1 46
			23a. Part1. Enter the shock, or heart t	disease, or comp failure. List only	olications that cause one cause on each I	d the death. ine.	Do not ente								Approximate Interval Between
	Pnysician	- 11	Immediate Cause (Fi	nal	a	A	cute l	Myeloi	id L	uekemia				3	Onset and Death months
1	/Medical Examiner		resulting in death)	(Due to (or as	a conseque	ence of):								
		<u>-</u>	Sequentially list cond	itions,	b. — Due to (or as	a conseque	ence of):								
	uted d ansit	Examiner	if any, leading to imm cause. Enter Underly Cause (Disease or inj that initiated events	ring jury		,									
oʻ	an an rial-tr	Еха	resulting in death) Las	st	Due to (or as	a conseque	ence of):								
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edlcal		•	d				_					_	
	ertific Jing p	Mec	IF FEMALE:	T	OOs Huss sutsame									_	
Вох	that the death certif ned by the attending detached for use a	Physician/M	23b. Was decedent p in the past 12 mg	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal c	leath 3□	Ectopic pre Other (spe				2	3d. Date Mont	of deliver	y Day Year
P.O.	the de	nysic	1 □ Yes 2 □ N 9 □ Unknown	No	9☐ Unknown	t till or doe	iii 5L	Other (spe							
	res that signed b be deta	by Pt	Part II. Other significa	ant conditions of	ontributing to death t	out not result	ting in the ur	nderlying ca	use give	n in Part I.	23e. Did t	obacco u	se contrib	oute to the	e cause of death?
of Vital Records,	w require: been sig should b	ed p									10,	res 2	§No 3	B ☐ Proba	ably 4 □Unknown
တ္တ	e law requ has been je 2 shoulk	Completed									24a. Was				sy findings available
Ä		Com									perfo	rmed?	de	ath? ☐Yes 2	•
/ita	Physicien: The lar this certificate has ral director, page 2	Be	25. Was case referred examiner?	-	11						eath (Check only o	ne)			0.0000
£	physi this c	70	1 Yes 2XNo)	Hospital: 1 💆 Inpati		R/Outpatien		-	4 L Nursing	Home 5 ☐ Resid				
	e fe	lon		5 Pending investigation	28a. Date of Inju (Month, Da	iy Year)	28b. Time of Injury	M 28	Sc. Injury Work	at ? ′es 2 ⊡No	28d. Describe I	now injury	occurre	a	
Division	Attender death	fica		6 Could not be determined	28e. Place of In	jury - At hom	ne, farm, stre		111		28f. Location (S	Street and	l Number	or Rural	Route Number,
ă	s after	Certification:	4 Homicide	201011111102	building, e	tc."(Specify)					City or To	vn, State)			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier 11 (Check only 2) one)	Certifying Ph	ysician: To the best liner: On the basis of and manner st	of examination	ledge, death on and/or inv	occurred a restigation,	t the time	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) date and	and mani place, ar	ner as sta nd due to t	ited. the cause(s)
	To th within To th	Me	29b. Signature and litt	le of certifier	4			29c.	License	number		29d. Date	signed	(Month, D	Pay, Year)
	10		> // / X	WO	12			Ĩ)3	103		j	13	1>	1406
	, ,		30. Name and address	s of person who	completed cause of	death (Item 2	23a) (Type, I	Print)		- 1	3 - 7		1.	,	
			31. Date filed (Month,		32 Regist	ar's Signatu	() ()(CLEA	100	21 /	TUMA	RF	MI) 2	1231
	Sta Registr			N 1 5 200		Li G digitato	B	Spa	Ma	1					

			1 - For State Registrar	State o	of Marylar		artmen <i>tificat</i>			Mental Hy	giene?	004	02531
	Dhari		1. Decedent's Name (First, Middle, La	st)						2. Date of De Month	ath Day_	Year ,	3. Time of Death
_	Physic /Medi		Robert Haddaway S	Spear						/	15.	2004	0550 M
	Exami	ner	4a. Facility Name (If not institution, give						Location of Deat	h		nty of Death	
			Peninsula Regiona 5. Social Security Number 6.5		7. Age (In yrs.		Sa.l	Lisbu		O Data of Rid	Wico		lana (Chaha as Essaisa
	Funeral Director		215-20-0961	ŽM 2□F	7.7	Yrs.	Months		Hours Min.		y, _{Year)} 1926	Mary1	ece (State or Foreign try) and
	b		Usual Residence of Decedent							riar · o,	1,720		
	arylar show	_	10a. State 10b. County			ty, Town or Lo	cation					11	0d. Inside City Limits 1 X Yes 2 ☐ No
	he M	Director	Maryland Dorchest 10e. Street and Number	er	V	ienna	101 7	0 - 1 -			10- 011	-414/5	
-	with with	급	309 Race Street				10f. Zip		869		-	of What Coun ISA	try r
	036 (Q.A.S. suit the Marylan air, or items 23a or 28a-f show Examinat must be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. \	Was Deced			Specify Yes or No to Rican, etc.)		lace - America	an Indian,
	6 after or its		1 X Never Married 2 ☐ Married	Armed Fo	2 TX No		fYes, sp <i>ec</i> 1 □ Yes 2		in, Mexican, Puer Specify:	to Rican, etc.)		Black, White, e	etc.
	5-0036 (7.72 hours after dea	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ates:						Spec	W	hite
	21215-0036 d within 72 hours att giene. sr than "natural", or sr than "matural", or it the Medical Exami	Completed	15. Decedent's E (Specify only highest gra	ducation ide completed)		16a. Deced	ient's Usua kind ol wor DO NOT us	il Occupa nk done d	ation during most of wo I)	rking	16b. Kind of	Business/Ind	lustry
1	vithi iene.	l mo	Elementary/Secondary (0-12)	Coltege (1-4or 5+)		armen		,		Aρ	ricult	ure
18		BeC	17. Father's Name (First, Middle, Last						18. Mother's Na	me (First, Middle,			
9.	Vlar	2	Alton Haddaway Sp	ear		,			Dele	ma Irene	Corkr	an	
\	Maryland 2121 Id 2 should be filed within in 2 should be filed within the and Mental Hygiene. Z7 is marked other than "traumatic svent, tite Mental the Men	1	19a. Informant's Name/Relationship (1	-			ural Route Numbe			Code)
1	re, Mg s 1 and 2 f Health a item 27 le		Gene C. Spear, Sr	./Broth						a, Maryla Date		n - City or To	an State
0	O Ses		1 ⊠ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif			Place of Dispo cemetery, cren				8/2004		•	
G	Baltim permit. Pag Department Importent: eny injury once.		21. Signature of Funeral Service Lices) 100								Tand
11	Balt permit. Departr Importe eny inji		Sovard	2	Sell	Ze 10	ller 06 Mai	Fun in S	eral Hom treet. E	e, P. O. ast New	Box 2 Market	.07, .MD 2	1631
	*	(23a. Part1 Enter the disease, or comshock, or heart failure. List only	plications that one sause on	caused the deat		er the mode	e of dyin	g, such as cardia	or respiratory ar			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		led 111		- 0	151	hythmi	ease			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq			10	1 1				
		-0	Sequentially list conditions, if any, leading to immediate	b. Due to	COYO		41	1111	9 011	POSE			
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			14121							
	760, be executed sician and burial-transit		resulting in death) Last	Due to	(or as a conseq	(uence of):							
	58760, icate be exc	Ical		d									
	Box 687(death certificate the attending physical for use as the the terminal for the termi	Physiclan/Medl	IF FEMALE:	220 H 1100 011							-		
	Bo Bath c attend for us	clan	23b. Was decedent pregnant in the past 12 months?	1☐Live b	tcome of pregna pirth 2 ☐ Feta nant at time of d	ıl death 3 ☐	Ectopic pre					Date of deliver Month	'y Day Year
	P.O.	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn			TO THOS (Spe	JUNY					
	IS, P	by PI	Part II. Other significent conditions of		eath but not res	sulting in the ur	nderlying ca	ause give	en in Part I.	23e. Did to	bacco use co	ontribute to the	e cause of death?
	Cords	edk	Trachial Ste	W0513						1 🗆 Y	es 2 No	3 Proba	ibly 4 Dinknown
	ecc law re as be	Completed								24a. Was autop		. Were autop	sy findings available
	The tracte has	Con								perfor 1 ☐ Yes	med?	death? 1 ☐ Yes	
	Vital Fician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	_	-		Othe	pro-core and according	ath Check onl or			
	Of Phys	1: To	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 of Injury	ER/Outpatien 28b. Time of			4 Nursing F	lome 5 Resid			1
	ion on anding Fath.: After a funer	atlor	1 Natural 5 Pending 2 Accident investigation		th, Day Year)	Injury	М	Bc. Injury Work	(? Yes 2 □ No		, ,		
	Division of Vital Records, storage and or Attending Physician: The law requires the after death. I Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification;	3 Suicide 6 Could not b	286. Place	of Injury - At he	ome, farm, stre	et, factory	, office		28f. Location (S City or Tow	treet and Nun	mber or Rural	Route Number,
	Itel or raft Dije	Cer											
	Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	niner: On the b	asis of examina	owledge, death ation and/or inv	occurred a estigation,	at the tim	ne, date and place pinion, death occu	, and due to the d rred at the time, d	ause(s) and r late and place	manner as sta	ited. the cause(s)
_	To the within 2 To the complet	Med	29b. Signature and title of certifier	and man	ner stated.		29c.	. License	number	2	29d. Date, sign	ned,(Month, D	av, Year)
	F ≱ F 8		10/10/1	e sents			H	6005	9368		1/15	164	,,
			30. Name ddress of person who	completed caus	se of death (Item	n 23a) (Type, (1 6		
	7		- Jahn Val	Viscoli	100 €	Carrol	SE.	Sal	ishung N	10 2180	۴		
		ate	31. Date filed (Month, Day, Year)		egistrar's Signa	ature			,				
	Regist	4.7	JAN 162	004	Mary 1	B 6		Apr.					
	DINVILLY REV 1/2	.001				ORIGINA	AL.						

State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 13 2004 Henry Simmons Stephens January 10:15 a^M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mallard Bay Care Center Cambridge Dorchester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 23, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months 92 214-12-6457 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Dorchester Cambridge Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 Rambler Road 21613 U.S.A. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) unknown commercial waterman seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oliver Stephens Lydia S. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paige English niece 610 Locust St., Cambridge, MD 21613 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Salisbury Crematory 1/14/04 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Brun 700 Locust St., Cambridge, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATherose lesofic heart disear **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 Fetal death ţó in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown as been signal Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No After this certificate has funeral director, page 2: autopsy performed 1☐ Yes 2₺No 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Invursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 Mo 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attending Injury 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) D 56659 1/13/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMISKINGE" MUHAMMAD 500 32. Renata's Signature 31. Date filed (Month, Day, Year) State

Registrar

P.0.

		Fype or Print in State of Maryl	land / Depa		Health and M		ne 20	04	025	33
	1. Decedent's Name (First, Middle, Last,)				2. Date of Deeth		,	3. Time of De	ath
Physician	William Thomas S	chrider. Ir				JAN 12		/ear	5:50 1	t M
/Medical Examiner	4a Fecility Neme (If not institution, give		•		4b. City, Town, or Lo	cation of Death	4c. County of		J.JU.	71-1
	Salisbury Rehab an	d Nursino C	enter		Salisbury	, Md.	Wico	місо		
Funeral	5. Social Security Number 6. Sec	x 7. Age (In	yrs. lest birthday)	If Under 1 Yea Months Dey	r If Under 24 Hrs.	8. Date of Birth (Month, Dey, Ye	ear)	9. Birthpla Country	ce (State or Fo	oreign
ector	579-26-6687	7	6 Yrs.			July 13,	1927 V	Vashi	ngton,	DC
_	Usuel Residence of Decedent 10a, State 10b, County	100	. City, Town or Lo	cation				100	I. Inside City L	imits
by Funeral Director	Maryland Montgom	ern	01ney						1 ☐ Yes 2	No No
Te C	10e. Street end Number	Cly	Officy	10f. Zip Code	l'i	10g	Citizen of Wh	at Country	/?	
₫	4519 Boastfield L	ane		208	332		USA			
Funeral Director		12. Was Decedent Ever	in U,S. 13.		Hispanic Origin? (Spuben, Mexican, Puerto	ecify Yes or No-	14. Race -			
	1 Never Married 2 Married	Armed Forces? 1 ⊠ Yes 2 □ No		ir ves,specily Ct 1 ⊟ Yes 2 5xtN		rucan, etc.)		White, at	c.	
Š	3 ☐ Widowed 4 ဩDivorced	If Yes, Give Year or Dates: W	WII				Specify _W	nite		
etec	15. Decedent's Edu (Specify only highest grad		16e. Dece (Give	dent's Usual Occ kind of work don	upation e during most of work red)	ing 16i	o. Kind of Busi	ness/Indu	stry	
шþ	Elementary/Secondary (0-12)	College (1-4or 5+)			red)					
Be Completed	17. Father's Neme (First, Middle, Last)	2	Sa	lesman	18 Mother's Name	e (First, Middle, Mai	Retai			
Be	William T. Scl	aridar Cr			Marion S					
2	19a. Informant's Name/Relationship (T)		19b. Meili	na Address (Stre	et and Number or Run		itv or Town. S	tete. Zip C	ode)	
	William T. Schride	· .			leld Lane,					
	20a. Method of Disposition	20	Ob. Place of Dispo			Date 20d	. Location - C		n, State	
	1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	[etropoli		ν̈́ν	anuary 13 2004 — A	lexand:	ria.	Virvin	da
	21. Signature of Funeral Service License				ress of Facility Collins					
	Van la	nen			. corrins rsity Blvd				MD 209	01
	23a. Parl 1. Enter the diseas or compleshock, or hand tailure. List only or	ications that caused the							pproximate	
	shock, or near tailure. List only of	ne cause on eech line.						"	Inset and Dea	th
al er	Immediate Ceuse (Final disease or condition	Chames	of	fruit	lee in	Donaro	, du	11	100	01-
	resulting in death)	Chronic Due	to (or as a conse	quence of):	A			1	/	
al Examiner		CONOTE	1 Bgs	Fas	dense			19	201-	7
xan	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Due	to for as a conse	quence of):						
7	cause. Enter Underlying Ceuse (Disease or injury that initieted events	0.						-		
듛	resulting in death) Lest	Due	to (or es e consec	uence or):				1		
2		d						-		
SICIS	Part II. Other significant conditions cor	ntributing to death but not	t resulting in the u	nderlying cause	given in Part I.	23b. Did toba	cco use conti	ribute to t	he cause of g	eath?
Physician/Medic	3.					1 ☐ Yes	2□ No 3	B □ Proba	bly 4 Un	known
						-				
Completed						24a. Was an a performe	utopsy d?	avail	e autopsy find able prior to pletion of caus	
De la				- · · <u>- · · · · · · · · · · · · · · · · · · </u>				of de	ath?	
Son						1 ☐ Yes	214No	1 🗆	Yes 2□ No	,
e c	25. Was case referred to medical examiner?					h (Check only one)				
To	1 L Yes 25 No		2 ER/Outpatie	T 3LI DOA		me 5 Residend				
on:	27. Menner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey Yea	ar) 28b. Time o	W	juryat /ork? □Yes 2□No	28d. Describe how	injury occurred			
lcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Plece of Injury	At home farm st			28f. Location (Stree	at and Number	or Rural i	Route Number	r.
ert	4 ☐ Homicide determined	building, etc. (St	pecify)	oot, ractory, onto	~	City or Town, S	state)			
Medical Certification:	29a. Certifier 1 Certifying Physics	sician: To the best of my	knowledge, deat	n occurred at the	time, date and place,	end due to the caus	e(s) and man	ner as sta	ed.	
<u>ö</u>	(Check only 2 Medical Exami one)	ner: On the basis of exar end manner stated.	mination end/or in	vestigation, in my	y opinion, death occurr	ed at the time, date	and place, an	d due to t	ne cause(s)	
¥.	29b. Signature end title of certifier	1/		29c. Lice	nse number	29d	Date signed	(Month, D	ay, Year)	
	1/1/	1		1	2830	P	1/2/09	4		
	30. Neme and address of person who co	ompleted cause of death	(Item 23e) (Type,	Print)	1-()	1				
		sins, Mi	D.	1346 S.	Division S	St.Suite,	Salisbu	ry,	Md.2180)4
	31. Date filed (Month, Day, Year)	32. Pegistrar's S	Signeture	book	Sil .					
State egistrar	1 . 111.	sins, Mi	D .			St.Suite,S	Salisbu	ıry, İ	Md.	2180

Registrar DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 14, 3:45 AM^M January 2004 Η. Sessions Kay /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Manor Care Bethesda Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 94 6,1909 Texas 336-10-4540 April Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "natural", or itams 23a or 28a-f ahow idical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number e filed within 72 hours after death with tall Hygiene.
I other then "natural", or items 23a or 2 ā 20877 United States 6530 Domocracy Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Writer Public Relations 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked MacClanahan Hall Marie Thomas Ε. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a 26 South Frederick Ave. #203, Gaithersburg, MD 20877 Nancy S. Edwards / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 16, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or page. P 1 4 ☐ Donation 5 ☐ Other (Specify) 2004 Beltsville, MD Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service M00382 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Steple D. Shuram 20891 Approximate fnterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Arrhythmia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 💢 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Pneumonia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ₹ No this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural fnjury 5 Pending 1 Tyes 2 No s after death. investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies allleni D42518 January 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani, M.D.; 11119 Rockville Pike #401; Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State aarka JAN 1 6 2004 Registrar

			1 - For State Registrar	State of	Marylan		artment o			Mental Hyg	giene	004	02535
			1. Decedent's Name (First, Middle, L	.ast)						2. Date of Dea Month		Yeer	3. Time of Death
	Physici /Medic		Louise Padge	tt Sherz	er					Januar		2004	6:20P M
	Examin		4a. Fecility Name (If not institution, g	ive street and numb	er)		4b. City, Tow	n, or Loca	ation of Dea	ath	4c. Co	ounty of Death	
			Rockville Nursin				Rockv					ntgome	
	Funeral		5. Social Security Number 6. 215-36-4473	Sex 7. 1 ☐ M 2 🖾 F	Age (In yrs. I	last birthday) Yrs.	If Under 1 Y Months Da		Jnder 24 Hi ours Mi	n. (Month, Day	r, Year)	Cou	place (State or Foreign
	Director		Usual Residence of Decedent		86	113.				July 1,	191/	Sout	h Carolina
	yland now		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Mar Mar	tor	Maryland Montgor	nery		Poole:	sville						1 Yes 2 No
	or 28	Directo	10e. Street and Number				10f. Zip Cod				_	n of What Cou	•
	23a	rai	17108 Butler R	oad				20837				ted Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show any injury or other traumatic event, If a Medical Examinar must be notified at once.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceded Armed Force 1 Tes 2 If Yes, Give Year or Date	es? ☑ No	1	Was Decedent f Yes, specify (1 ☐ Yes 2🛣		nic Origin? exican, Pue pecify:	(Specify Yes or No- arto Rican, etc.)		. Race - Ameni Black, White, pecify: White	etc.
21215-0036	2 hou	ted	15. Decedent's				ient's Usual O				16b. Kind	of Business/In	dustry
2	thin 7 9. Medi	Completed	(Specify only highest g Elementary/Secondary (0·12)	College (1-4	or 5+)	life. I	kind of work de DO NOT use re	one durinț otired)	g most of w	orking			
2	or the	Con		3_		Reg	istered					spital	
Maryland	d oth	Be	17. Father's Name (First, Middle, La	,						ame (First, Middle,	Maiden Su	imame)	
<u>Y</u> a	ould Men Parke	2	Philip Madison						va Ra		-		
a	12 sh h and 7 Is m traum	2 -1	19a. Informant's Name/Relationship		. 1.					Rural Route Numbe			
e,	1 and Healt em 2 ther		Patricia Louise I	Marshall/	20h P	lace of Dieno	cition /Mama a	4	id, Po	Olesville Date		ryLand tion - City or To	
5	nt of nt of t: # #		1 ☐ Burial 2 ☐ Cremation 3		ale		natory or other			uary 14,			
Baltimore,	artme ortan injury	. 4	* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		FOL		oln Cen . Name and A						aryland
Ba	Dep Imp	y 1	* AFRAGE	- '	M01356	Ro Ro	ckvill ckvill	e, Ii e, Ma	nc. 30 aryla	00 West M nd 20850	ont 80 -2805	mery Av	neral Home/ venue,
15.			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau ly one cause on eac	ised the death th line.	n. Do not ent	er the mode of	dying, su	ch as cardi	ac or respiratory ar	est,		Approximate Interval Between Onset and Death
	Physician	9	Immediate Cause (Final disease or condition resulting in death)	a. Seps:									
	/Medical Examiner		iosaring in south)		as a consequ								
Н	\$45°C	-	Sequentially list conditions, if any, leading to immediate		zophrei as a consequ								
	nted	i i	Cause (Disease or injury	Diab									
,	exect n and ial-tra	Examiner	that initiated events resulting in death) Last	U	as a consequ	uence of):							
8760,	icate be executed physician and s the burial-transit	edical	•	d. Hyper	rtensi	on							
9 x	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outco	me of pregna	ncy					230	. Date of delive	20/
.O. Box	The law requires that the death certificate be executed as bear signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		h 2 Fetal nt at time of de m		Ectopic pregna Other (specif)				250	Month	Day Year
ري ت	res that signed b	by Pi	Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the ui	nderlying cause	given in	Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
ğ	v require been sig should b									1 □ Y	es 21 ∑ î	No 3☐ Prot	pably 4 Unknown
Records,	The law require has been bage 2 should	Completed								24a. Was a autop perfor 1 ☐ Yes	sy med?	prior to co death?	psy findings available mpletion of cause of
ta	ian: rtifice ctor, p	Be C	25. Was case referred to medical examiner?			-		26.	Place of D	eath (Check only or			
<u>~</u>	Physician: r this certific ral director,	To	1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatien	t 3 DOA	Other: 4	Nursing	Home 5 Resid	ence 6	Other (Specif	(y)
<u>_</u>	ng Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month,	Injury Day Yeer)	28b. Time of Injury		njury at Work?		28d. Describe h	ow injury o	ccurred	
Sio	Attending ir death. actor: After by the fune	cat	2 Accident investigat 3 Suicide 6 Could not	he				1 🗌 Yes	2 🗌 No	00/ 1 22 /0			
Division of Vital	l or At after o Dirac	Certification:	4 Homicide determine	288. Place of	, etc. (Specify	ome, farm, str	eet, factory, off	ice		City or Tow		iumber or Hura	al Route Number,
_	ospitel hours uneral ly filled		29a. Certifier 1 Certifying	Physician: To the basaminer: On the bas	est of my know	wledge, death	occurred at th	e time, d	ate and pla	ce, and due to the o	ause(s) an	d manner as s	tated.
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	Medical	29b. Signature and title of certifier	and manne	r stated.	COLL STREET		ense nur				igned (Month,	
,	To To		250. Signature and title of certifier	11					,				
	10		30. Name and address of person wh	Han	m	220) 7		3272		J.	anuar	y 13, 2	2004
			Sunita Hanjura,					#111	. Roc	kville. N	(arv1:	and 20	854
	Sta	te	31. Date filed (Month, Day, Year)	32. Beg	istrar's Signa	turn A	Span		, 1.00				
	Registr	ar	JAN 142	004	auras	G	papour						<u>-</u>

			1 - For State Registrar	State of Ma	aryland		irtment of H tificate of L	eaith and iv D <i>eath</i>		ene2000	4 02536
	Physici	an	1. Decedent's Name (First, Middle, La		CD				2. Date of Death Month	Day Yee	3. Time of Death
Ŀ	/Medic Examir	al	ELMORE H S 4a. Fecility Name (If not institution, given	STEWART e street and number)	SR		4b. City, Town, or	Location of Death	JANUARY	11, 2004	
	LAGITIF		8909 ALBERT STEW	VART LANE			SILVER	SPRING		MONTGON	MERY
	Funeral Director		201-03-3601	Gex 7. Ag IXIM 2□ F	e (In yrs. last 83	birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCT 31,		Birthplace (State or Foreign Country) ARYLAND
	/land		Usuel Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation	-			10d. Inside City Limits
	a-fah	ctor	MD Montgon	nery	Silve	r Spr	ing				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Code	-	10	g. Citizen of What	Country?
	s 23a	erall	8909 Albert Ste			140.14	2091		7 17	U.S.A.	
9200-51212	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-f ahow avent, the Medical Exameter inset by notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent 1 Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cubal ☐ Yes 2⊠ No	spanic Origin? (Spon, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify:	
ر	72 ho 'natur dical	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	1	6a. Deced	ent's Usual Occupa	ition furing most of works)	ing 16	6b. Kind of Busines	ss/Industry
121	e filed within 72 h al Hygiene. other than "natu vant, the Medica	Completed	Elementary/Secondary (0-12)	College (1-4or 5		`life. [Mecha)		aabina Wa	ndina
	Hygie other		12 17. Father's Name (First, Middle, Last,)		меспа	IIIC	18. Mother's Name		achine Ve aiden Sumame)	ending
Maryiand	should be ind Mental in marked of	To Be	Albert Stewart					Hattie B	udd		
lary	2 short		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	nd Number or Rura	il Route Number, (City or Town, State	, Zip Code)
	l and lealth m 27 her tr		Elmoria I. Stewar	t - Daught		8909	Albert St	tewart Ln			
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any njury or other traumatic as once.		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	n) L		1awn	sition (Name of latory or other place Mem. Parl	k 1–18–	04 R	ockville	, MD
ā	Departiment of the permitted of the perm		21. Signature of Funeral Service Licer	Tulus	ne			^{s of Facility} Hi Hampshire			ing, MD 20904
	Physician /Medical Examiner		23a ent1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line a. Pneumon: Due to (or as a b. Dementia)	La a consequen		or the mode of dying	, such as cardiac c	r respiratory arres	t,	Approximate Interval Between Onset and Death Weeks
, o	ifficate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Cerebro Due to (or as a	Vascu	lar D	isease				Years
58/6U,	physic physic the b	edical		d							
O. Box o	death cer e attendin id for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the line birth 4 Pregnant at 9 Unknown	2 Fetal dea	ath 3⊡	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
ras, r	requires that the een signed by th hould be detache	d by Pl	Part II. Other significant conditions of Decubitus ulcers	ontributing to death bu	it not resultin	g in the un	derlying cause give	n in Part I.			to the cause of death? Probably 4 □Unknown
Records	ed S CA	Completed by	Urinary tract in	ection					24a. Was an autopsy performe	d? prior to	autopsy findings available ocompletion of cause of
	yaician: The is certificate ha director, page	Be (25. Was case referred to medical examiner?	112-1				26. Place of Death			
5	는 문을	tlon: To	1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie	288	Outpatient b. Time of Injury	28c. Injury Work	4 Nursing non	ne 5🛣 Residence 8d. Describe how	ce 6 Other (Sp injury occurred	ecify)
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, (Specify)	farm, stre		_	28f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical	29a. Certifier 1 ★ Certifying Ph (Check only one)	ysician: To the best on niner: On the basis of and mariner stat	examination	dge, death and/or inve	occurred at the time	e, date and place, a nion, death occurre	nd due to the caused at the time, date	se(s) and manner a and place, and du	is stated. le to the cause(s)
	To the comp	W	29b. Signature and title of certifier	Ma.	en	N	29c. License	number 2 Z Z 3 _	29d.	Date signed (Mon	oth, Day, Year)
			30. Name and address of person who	completed cause of de	ath (Item 23		rint) necticu	+ A10	Kensi	noton	MD 20895
e S	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 6 20	32. Tegistra		5	Sparks	1	(1000)	7	, , , , , , ,

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar/MEND#26per/MDI	State of Maryland /15/04,BW,McCo		artment of Hertificate of L			iene 2 () eg. No.	0	02537
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	th Day	Year	3. Time of Death
	/Medio		Hugh C.	Stith		# 05 T			9, 200 4c. County		11:09a M
	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, or Hyatts		ı(n	Prince		ro a c
46	Funeral		6203 Balfour Drd 5. Social Security Number 6. S		st birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth			lace (State or Foreign try)
	Director		579-26-0319	⊠M 2□F 78	Yrs.	Months Days	Hours Mi		1925	Flor	ida
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c City	. Town or Lo	cation				11	0d. Inside City Limits
	Aaryla f sho	ō	Maryland Prince							'	1 ☐ Yes 2∏ No
	28a-	Directo	10e. Street and Number	George's ny	attsv	10f. Zip Code		1	0g. Citizen of W	/hat Coun	try?
	ath with the Marylan s 23a or 28a-f show		6203 Balfour Dri	v e		207	82		USA		
	ems :	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.			Specify Yes or No- irto Rican, etc.)		- Americ	
20	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🔀 No		,		Whit	
Ş	within 72 hours after death with the Maryland ene. then "naturs!", or items 23a or 28a-f show the Modical Exerting Frinal be multified at	ed p	15. Decedent's E	Year or Dates: WWII		ient's Usual Occupa	tion		16b. Kind of Bu		
215-0036	hin 72 nn "ne Madis	plet	(Specify only highest gra Elementary/Secondary (0-12)		(Give life. l	kind of work done d DO NOT use retired)	uring most of w	orking			
7	er tha	Completed	Elonionally (0 12)	4	Admi NRA	nistratio: Publicati				Assoc	iation
	be filed ital Hygid od other event.	Be	17. Father's Name (First, Middle, Last,				18. Mother's N	ame (First, Middle, I	Maiden Sumame	e)	
<u>S</u>	should be and Menta marked umatic ev	2	Milton C. Std 19a. Informant's Name/Relationship (10b Mailie	Address (Street a		abeth Brow Rurai Route Number		Ctata Tia	Code
Maryland 21	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic			•							
	f Heal		Tracey Stith/Da 20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other place			20c. Location -		
Ê	Pages nent of int: If It		1 ☐ Burial 2 TxCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specil	Hemoval from State		tan Crema	Ja	nuary 11 2004	Alexand	lria.	ΨΔ
saltimore,	permit. Pages Department of Important: If I any injury or		21. Signature of Funeral Service Licer		22	. Name and Address	s of Facility	554 MREET			107
D	% Q E ≅ 9		(inchew)	Jole	<u>5</u> 5	Univers	ity Bly	d. W., Si	lver Sp	ring	MD 20901
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only tmmediate Cause (Final disease or condition resulting in death)	1 6 2	RESP	FATERY	ARRE	ST	531,		Approximate Interval Between Onset and Death
8/60,	certificate be executed ding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to The Clate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence) d.							
O. Box 6	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delive	ry Day Year
д ў Г	The law requires that the de ste has been signed by the a page 2 should be detached	þ	Part II. Dther significant conditions of	contributing to death but not resu	lting in the u	nderlying cause give	n in Part I.			bute to the	e cause of death?
Kecords,	w require been signated should t	etec						24a. Was a			sy findings available
		Completed						autops	y ned? de	rior to con eath?	apletion of cause of
Vital	certification	Be	25. Was case referred to medical examiner?	Hospital:		Othe		eath (Check only on	*		
	Phys rthis ral di	1: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2 E	R/Outpatien 28b. Time of	T 3LI DOA	-4	5 AReside	nce 6 Othe)
0	ding F th: : After s funera	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury Work' M 1 □ Y	? es 2 ☐ No		,,		
Division of	tal or Attending Physician: rs after death. al Director: After this certific ed in by the funeral director.	Certification:	3 Suicide 6 Could not be determined		me, larm, str	eet, factory, office		28f. Location (St. City or Town		or Aural	Route Number,
	To the Hospital of within 24 hours af To the Funeral D (completely filled in	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Example (Check only one)	nysician: To the best of my know niner: On the basis of examinati and manner stated.	rledge, death on and/or inv	n occurred at the time restigation, in my op	e, date and place inion, death occ	ce, and due to the ca curred at the time, da	use(s) and mar ate and place, a	nner as sta nd due to	ated. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	11 3		29c. License	number	25	9d. Date signed	(Month, E	Day, Year)
•	15+1		· (K)	Wen		D 30	769		11910	4	
			30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) Alle Poi	nt de	GREENA	ELT 1	MIS	00770
is.	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signati	Lire Li	Ana de	/	,		-	-

			1 - For State Registrar	State of Ma	aryland	/ Depa	artment rtificate	of H	ealth a Death	and Me		iene	200	4 02539
ı	Physic		Decedent's Name (First, Middle, L John	ast)	9	Stear	ns			i	2. Date of Dear Month January	Day	2004	3. Time of Death 8:14PM M
	/Medi		4a. Facility Name (If not institution, gr	ve street and number)			4b. City, T	own or	Location o		anuary		County of Dea	
	Exami	ner	Holy Cross Hospi						Sprin				ontgome	
	Funeral				e (In yrs. last	t birthday)	If Under 1	Year	If Under	24 Hrs. 8	B. Date of Birth		9. Bir	thplace (State or Foreign
ac T	Director		Unavailable	12 M 2□F 55		Yrs.	Months	Days	Hours	Min.	B. Date of Birth (Month, Dey, une 10	Year) 19	C	ountry)
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	anation.							Later
	laryla Pho a	ō												10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-1	ect	Maryland Montgor	nery	Rocky	ville	10f. Zip C	and a				0- 000		
	with a second	ā	1406 Stratton D	civo			2085					-	zen of What Co ted Sta	•
	leath	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13 1			nanic Orig	nin? (Spec			I4. Race - Ame	
' O	r Her	F	1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 □ 1							fy Yes or No- can, etc.)		Black, Whit	
8	72 hours after death with the Maryland neture!', or Items 23a or 28a-f show alone from the netified at	Completed by	3 ☐ Widowed 4 🏝 Divorced	If Yes, Give Year or Dates:	1967		1 ☐ Yes 2	₩ No	Specify:				Specify: Wh:	ite
2-0	72 ho	eted	15. Decedent's E (Specify only highest gi		1	6a. Dece	dent's Usual	Occupa	tion	t of working		16b. Kir	nd of Business	/Industry
2	Althin Den Den	jdu	Elementary/Secondary (0-12)	College (1-4or 5	i+)		kind of work DO NOT use		aning most	i or working	·			
2	fled v flygier	ဒီ	12 17. Father's Name (First, Middle, Las			Hom	emaker		40. 14:4:				n Home	
and	ntal hed of	Be	Unavailable	1)						rs Name (availa	First, Middle, M ahle	Aaiden .	Sumame)	
Ž	hould d Me mark matic	မ	19a. Informant's Name/Relationship	(Type Print)		10b Mailie	Addross (Street			Route Number,	0:1	T	7.0.41
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injuryer other traumatic avant, the Medical Examiner must be notified at once.		·	Life Compa	- 1	406	Stratt	on]	Drive	Roce,	kville	, MI	2085	
ē,	f Heal		20a. Method of Disposition	·	20b. Place	of Dispo	sition (Name	of	1	Dat	e :	20c. Loc	ation - City or	Town, State
Ë	Page onto		1 ☐ Burial 2 ☐ Cremation 3 (1 ☐ Donation 5 ☐ Other (Special Control of Cont		1	-	natory or othi ce Crei		' ⊦т.	an. 14	4, 2004 _E	Belt	sville	MD
a	mit.		21. Signature of Funeral Service Lice			22	. Name and	Address	of Facility	у _				
Ö	89 5 8 8		Forma 3	Franker Mc	171.1	R	app Fu 33 Gis	ner st A	al Ar venue	nd Cre ≥ Silv	emation ver Spr	Sei ing	rvice MD 2	0910
	r.i		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death. D	Do not ente	er the mode	of dying	, such as	cardiac or r	espiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Sepsis										Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as		ce of):								
			Sequentially list conditions,	Pneumo										
	pe lisit	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequen	ce of):								
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	ce of):								
760,	siciar buria	ical		ď										
68	ifficati g phy as the	edic												
ŏ	leath certific attending p i for use as t	2	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome								2:	3d. Date of del	ivery
P.O. Box	deat	Physician/Med	in the past 12 months? 1 \(\sum \) Yes \(2 \sum \) No	4☐Pregnant at			Ectopic preg Other (spec						Month	Day Year
o O	thet the de ned by the a detached f	hys	9 🗆 Unknown											
	igned be dei	by	Part II. Other significant conditions	contributing to death bu	it not resultin	g in the un	derlying cau	se giver	in Part I.		1			the cause of death?
ord	w requir been si should	ted	Cirrhosis							_	1 🗆 Ye:	s 2 🗆	lNo 3∏Pr	obably 4 🖺 Unknown
Ö	has by	Completed	Renal Failure								24a. Was an autopsy	,	24b. Were au	topsy findings available completion of cause of
=	: The	Co									perform 1 ☐ Yes 2	ed?	death?	2 🖾 No
<u> </u>	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:							Check only one			
0	Physician: The la this certificate har ral director, page 2	To.	1 Yes 2 No	1 Alnpatie	nt 2 EPV	Outpatient o. Time of		Other	4 🗀 1401		5 Resider			oify)
ou	ding I h. After funer	tion	1 ☑Natural 5 ☐ Pending	(Month, Day	Year)	Injury	M	. Injury a Work?	at es 2 □ N	- 17	I. Describe hov	v inj <i>u</i> ry	occurred	
Division of Vital Records,	I or Attending after death. Director: After I in by the fune	fica	3 Suicide 6 Could not b	e 29a Blace of laiv	rv - At home.	farm stre			3 2 1		Location /Stn	aet and	Number or Ru	ral Route Number,
É	5 E E	Certification:	4 Homicide determined	building, etc	. (Specify)		or, radiory, d				City or Town,	State)	770,100, 0, 710	rai i noste i vuinibei,
	bours hours unere		29a. Certifier 1⊠ Certifying PI	nysician: To the best of	f my knowled	ige, death	occurred at	the time	, date and	place, and	due to the car	JSO(S) a	nd manner as	stated.
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in	Medical	one) 2 Medical Exal	miner: On the basis of and manner sta	examination .	and/or inv	estigation, in	my opir	nion, death	h occurred	at the time, da	te and p	lace, and due	to the cause(s)
	To T	Σ	29b. Signature and title of certifier	/((),	_			icense r					signed (Month	
•	4			WIN				743	47			-08	-200	4
			30. Name and address of person who Neeraj Chopra	P.O. Box 8				9_1	MD 2	20883				
	Sta	te	31. Date filed (Month, Day, Year)	32. Begistra	r's Signature		0							
	Registr	_	IAN 1 2 20		na	13	2000	Carried Land	. 6					

STEARNS, JOHN

			For State Registrar	State of Ma		epartment of F Certificate of a		lental Hygie Reg.	Em to the	02539
	Physicia		Decedent's Name (First, Middle, L CLIFF			TOMPKINS		2. Date of Death Month	Day Yeer 13 2004	3. Time of Death
3	/Medic Examin		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	
	Funeral Director		Atlantic Gen 5. Social Security Number 6. 212-14-1229		(In yrs. last birt	Berlin Hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye		Cer lace (State or Foreign http) Md.
	pu 🔭		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				0d. Inside City Limits
	shoy	ō	Md. Worces	ter	•	Pines			,	1 ⊠Yes 2 □ No
	with the Maryland or 28e-f show	Director	10e. Street and Number	CCI	occuii	10f. Zip Code		10g.	Citizen of What Cour	itry?
	h with		12 Battersea	Rd.		2181	1	l v	Vorcester	-
36	72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show citical Examinat must be inclided at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 MYes 2 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗷 No			14. Race - Americ Black, White, Specify: Whi	an Indian, etc.
215-0036	in 72 hou n "nature Wedical E	Completed	15. Decedent's l (Specify only highest g Elementary/Secondary (0-12)	Education		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	eation during most of working d)	ng 16b	b. Kind of Business/Ind	dustry
	od within giene. er than "I	E	1 2	College (1940) 3	T)	Carto	grapher		USGS	
	be filed ntal Hygi od other event,	Be	17. Father's Name (First, Middle, Las					(First, Middle, Maid		
<u>Ş</u>	Mer Mer arke	၉		pkins	105	Mailia - Adda - (Out		da Schle		0.43
Maryland 21	12 hall	1	19a. Informant's Name/Relationship Emma F. Tompk		F1	Mailing Address (Street 2 Batterse				
	is 1 and 2 of Health item 27 other tra		20a. Method of Disposition	ins Spou		Disposition (Name of y, crematory or other place			Location - City or To	
altımore,			1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	Removal from State		sbury Crem	ı	5-04 Sa	alisbury,	Md.
Balt	permit. Page Department of Importent: If any injury or		21. Signature of Fun Service Lice	enseed L	, , ,	22. Name and Addre	ss of Facility		erlin, Md	
			23a. Parti. Enter the disease, or conshock, or heart failure. List on	mplications that caused	the death. Do n					Approximate Interval Between
Y	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	VMOA a consequence of	حآر				Onset and Death
	Examiner	_	Sequentially list conditions,	b. Due to (or as a	a consequence o	Mr).		V		
_	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	2 00/130420/100 0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
68760,	ficate be executed physician and ts the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a	a consequence o	of):		<u>-</u>		
Box 68	ath certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1□Live birth 4□Pregnant at	2 Fetal death	3 ☐ Ectopic pregnancy	,		23d. Date of delive Month	ry Day Year
0.	at the by the tacher	hys	9 Unknown	9□ Unknown						
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the underlying cause giv	en in Part I.	23e. Did tobaco	co use contribute to the	e cause of death? ably 4 ∐Unknown
Vital Records,	The law re	Completed						24a. Was an autopsy performed 1 Yes 2 4	prior to cor death?	osy findings available inpletion of cause of
<u>ra</u>		BeC	25. Was case referred to medical examiner?				26. Place of Death			
	ding Physicien: h. After this certific funeral director.	ို	1 ☐ Yes 2 ☐ No			tpatient 3 DOA Oth	4 Li Nursing Hor		6 □Other (Specify)
Z C	ling P	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. T 'Yea <i>r</i>) Ir	njury Wor	yat k? Yes 2 □No	28d. Describe how in	njury occurred	
Division of	or Attendited of	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 200 Blood of Injur	ry - At home, fai :. (Specify)	m, street, factory, office		28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
_	To the Hospital or Ai within 24 hours after or To the Funerel Directompletely filled in by	edicai Ce			examination and	, death occurred at the tir dor investigation, in my o				
	To the within To the comple	Mec	29b. Signature and title of certifier		1	D. O. 29c. Licens	e number	29d.	Date signed (Month, i	Day, Year)
			30 Name and address of masses wh	n completed cause of the	agth (Itom 22a)	Type Print	1283		1/4/69	<i>(</i>
+	1.5+1		30. Name and address of person wh	U/Ks	9+33	HerlA	424 D.	14	Berla	MA
	Sta Registr		31. Date filed (Month, Day, Year) JAN 15	2004 32. Bagistra	ar's Signature	Sparle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 35PM SR 10 2004 OMas aNUary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner STON If Under 24 Hrs. albot a <u>itous</u>e If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Age (In yrs. last birthday) 5. Social Security Number **Funeral** 10 M 20 F Months Days Hours Min 5689 215-26-Director Mary land Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No a 51 **Funeral Director** albot 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21 USA 5 nionville 60 12. Was Decedent Ever in U.S. Amed Forces?
1 Pyes 2 No 95/1-1 Yes, Give Year or Dates: 1953 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 2 Married 1 ☐ Yes 2 No 1953 Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) aRMER 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ homas leaves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rd. Easton 9651 Unionyi 10 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Park 151 04 hards Mem, Eastow, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Add FUNERO Shington one uneral enRy MD. 21613 St. Cambrida 510 Wa 23a. Part1. Enfey the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician - Metastati Carcinson year S rostate /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Completed by Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 DUnknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has 2 No 1 ☐ Yes Hospital or Attending Physician: filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Hospice ၉ 1 ☐ Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death. To the Funeral Director: After Injury 5 | Pendina 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the s 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 47232 04 mo who completed cause of death (Item 23a) (Type, Print) Mary Spencer DeShields, M. 31. Date filed (Month, Day, YAN 14 2004) Stranger 509 Idlewild Ave., Easton, MD M.D 21601 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 1:15 РМ Wendell B. Tascher January 12, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Suburban Hospital Bethesda Montgomery 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□F 72 Yrs. Director 578-40-8765 May 11, 1931 Missouri Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "naturel", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director Maryland Montgomery Rockville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6830 Old Stage Road 20852 United States filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1956~1958 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No δ Specity: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) President/Chairman permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If item 27 I e marked other th
any folly go, other traumatic event, IIII
pncs. 5+ Savings & Loan Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wendell R. Tascher Evelyn LeManager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane G. Tascher/Wife 6830 Old Stage Road, Rockville, Maryland 20852 20b. Place of Disposition (Name of cametery, crematory or other place)

Neelsville Presbyterian 20a. Method of Disposition 20c. Location - City or Town, Stete January 16, 1 Burial 2 □ Cremation 3 □ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) 2004 Germantown, Maryland Church Cemetery 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee M00198 0 1300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Pent1. Form the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Liposarcoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death Year 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 № No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation or Attendation of the death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours all To the Funeral D 1 St CertifyIng Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of confifier 29c. License number 29d. Date signed (Month, Day, Year) 11+1 D21898 non January 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ernest D. Hanowell, M.D. 6410 Rockledge Drive, #403, Bethesda, Maryland 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State boarles! IAN 14 2004 Registrar

Bernach

wendell

State of Maryland / Department of Health and Mental Hygiene? (1) Certificate of Death 2. Date of Death Decedeni's Name (First, Middle, Last) 3. Time of Death Physician Month Year Erik Morsos Delcid Torres 01 10 2004 12:51am /Medical 4a. Fecility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Shady Grove Hospital Montgomery

8. Date of Birth
(Month, Day, Year)
May 23 1969 El Salvador 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1**∑**M 2□ F 34 Director Unavailable the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examinat total be notified at Md YEYes 2 No Montgomery Director Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or item in jury or other traumatic avent, it a Medical Exam car must be a page. 13420 County Ridge Drive 20874 ElSalvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, While, etc. ☐Yes 2☐No f Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Salvadorian Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Mechanic 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ciiotroii Delcid Torres Socorro Hermandez 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcial Batres (Friend) 29 Nancy Pl #1 Gathersburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State El Salvador 01/23/04 Sacienda Platanar 4 Donation 5 Other (Specify) ²² Name and Address of Facility
Snead Funeral Home & Cremation Service
5732 Georgia Ave NW Washington,DC 20011 21 Signature of Euneral Service Licenses Houcen 23a. Part I. Enter the disease percomplications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician Theumonia 10 days /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) physician and the burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760. physician use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. I ed by the a 1 Yes 2 No 9 Unknown signed by t The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No. 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Hospital or Attending Physician: rector, 25. Was case referred to medical Be 26. Place of Death Check only one examiner? 1 Dipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient Certification: To 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D0660117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric J. Park, MD Medical Rockerle, mD 9901 31. Date filed (Month, Day, Year) 32. Registrar's Signature oaks JAN 14 2004 Registrar

		Registrar 1. Decedent's Name (First, Middle, Las.	1)	Ce	rtificate of	Deam	2. Date of Death	. No.	3. Time of Death			
Physicia /Medic			Tukenmez			m-1	January	Day 13, 2004	1:23 P M			
Examin	er	4e. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	•			
Funeral		Suburban Hospital 5. Social Security Number 6. Se	7. Age (/n y	rrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		Montgomery 9. Birth	olece (Stete or Foreign			
Director		087-44-3608 15 Usual Residence of Decedent	□M 2⊠F 66	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) Oct. 14,	1937 Gern				
-f show	tor	10a. State 10b. County Maryland Montgome		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
a or 28a Lbe noti	Director	10e. Street and Number 4702 Langdrum Lan			10f. Zip Code 2081	5		Citizen of What Cou	*			
ms 23	era	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.		lispanic Origin? (Span, Mexican, Puerto		14. Race - Ameri	can Indian,			
el', or ite	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	an, Mexican, Puerto Specify:	Hican, etc.)	Black, White,	etc. Vhite			
n "natur Medical	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king 16	6b. Kind of Business/Ir	dustry			
arth a	E O	- Clotheritary/Secondary (0 12)	4	Home	emaker		(Own Home				
rked oth	To Be (17. Father's Name (First, Middle, Last) Walter Roeder				18. Mother's Nam Hilda H	e (First, Middle, Ma Iahn	iden Sumame)				
27 ie ma r trauma		19a. Informant's Name/Relationship (7 Ercan Tukenmez/ H						City or Town, State, Zipe, Marylane				
Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Serve) Lices:	Removal from State	remator:	matory or other place omery ium, Inc.	Janua 15,	20c. Location - City or Town, Stete 20c. Location - City or Town,					
Pepa Impo		> Attack	м0068	9 B	ethesda-C	hevy Chas	se, Inc.	7557 Wiscon	nsin Avenue			
ysician		23a. ant 1										
Medical aminer			Due to (or as a con									
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as a con:	sequence of):								
hysician and the burial-transit	cal	resulting in death) Last	Due to (or as a cond.	sequence of):								
the attending physion hed for use as the t	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deliv Month	ery Day Year			
igned by the atte be detached for		Part II. Other significant conditions co	entributing to death but not	resulting in the u	nderlying cause giv	en in Part I.		cco use contribute to t				
been sig	eted							2 No 3 Prof				
page 2 s	Completed						24a. Was an autopsy performe	prior to co death?	ppsy findings available mpletion of cause of			
certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		ott	O.C.	th (Check only one)					
Witer this	on: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day Yea	2 ☑ ER/Outpatie 28b. Time o Injury	f 28c. Injur	y at k?	ome 5 Residence 28d, Describe how	ce 6 Other (Special injury occurred	(y)			
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, st ecify)		Yes 2 □No	28f. Location (Stre- City or Town,	et and Number or Rura State)	al Route Number,			
Euneral Funeral letely filled	Medical (29a. Certifier 1X Certifying Phyone) 2 Medicel Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the til vestigation, in my o	me, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as s a and place, and due to	tated. the cause(s)			
within 2 To the complet	Me	29b. Signatur and title of certifier	ham	5 M	29c. Licens D30			Date signed (Month, anuary 14,				
				~ / /				-				

			For State	<i>,</i> ,		artment of H	łealth ar	nd Mental Hyg	6	04 0254	1;
			Registrar		Cei	rtificate of	Deam	2. Date of Dea	Reg. No.	2 Time of Day	
	Physicia	an	Decedent's Name (First, Middle,					Month	Day	Year 3. Time of Dea	
	/Medic	al	JUNE FRANC		TURNE		-1	JAN	. 12,		P^{M}
ſ	Examin	er	4a. Facility Name (If not institution,			4b. City, Town, o	kvill		•		
			National Lut 5. Social Security Number 6		In yrs. last birthday)	If Under 1 Year				TGOMERY 9. Birthplace (State or Fo	reian
	Funeral Director		431-88-5133		79 Yrs.	Months Days	Hours	Hrs. 8. Date of Birth Min. (Month, Day JULY 8	, 1924	9. Birthplace (State or For Country) Arkansas	
			Usual Residence of Decedent						•		
	how =		10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Li	
	e Me	cto	MD Mont	gomery	Gai	thersbu	ırg			1 ☐ Yes 2 €	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time 27 is merked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Evant for must be notified at any injury or other traumatic event, the Medical Evant for must be notified at once.	Funeral Director	10e. Street and Number	a - Dadas		10f. Zip Code	0070		10g. Citizen of W	•	
	ath w	rai	1048 Westsi				20878	n2/Consitu Van er Na		S.A. e - American Indian.	
	er de Itam:	nue	11. Marital Status	12. Was Decedent Event Armed Forces? d 1 ☐ Yes 2 X No	er in U.S. 13.	If Yes, specify Cuba	an, Mexican, i	n? (Specify Yes or No- Puerto Rican, etc.)	Blac	k, White, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 212 No	Specify:		Specify	Black	
8	tura stura	ed	15. Decedent's	Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	usiness/Industry	
75	n n	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most o d)	of working			
7	d with	Completed	Elementary/Secondary (5 12)	5+	Gui	dance C	counse	elor	Edu	cation	
Maryland 21215-0036	be file ital Hy id othe event	Be C	17. Father's Name (First, Middle, La	ist)				s Name (First, Middle,		e)	
<u> a</u>	wild b Menta	으	Will Carter					Charlene			
ar)	2 should and Mer is marke raumatic		19a. Informant's Name/Relationshi		1.			or Rural Route Numbe			
	1 and 2 Health tam 27		Francene Wal	ker (Daugh	A Second		side D	or., Galt.		rg, MD 208 City or Town, State	78
Ore	Pages 1 nent of H int: If ital		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	Removal from State		matory or other plac					
Ē	men tant:		`4 □Donation 5 □Other (Spe	ecity)				1/17/04		en, LA L HOME, P.	7
Baltimore,	permit. Departr Imports any inju		21. Si natula o Funeral Service Li	consee Man	1011 2					e, MD 2085	
_	20 = 8 Q		COn Part Star Publication of a	SULTURE that saved the	on death. Do not on	<u>_</u>				Approximate	•
			23a. Part1. Enter the disease, or c shock, or head failure. List of	nly one cause on each lin-			ig, such as or	ardiac or respiratory ar	lost,	Interval Between Onset and Deat	n th
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	rneum	ana_					
	Examiner			Due to (or as a d	onse uence of):	darine	Dis	00.02		10095	
		-	Sequentially list conditions,	b Due to (or as a	consequence of):	mers.	71(2	euse			
	ted f insit	듄	Sequentially list conditions, I any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events							year	}
Ć,	e be executed /sician and e burial-transit	Examiner	resulting in death) Last	c. Due to (or as a d	consequence of):						
760,		cai		d							
99	ntifica ng ph as th	Jed	IF FEMALE:				1.41				
Вох	th cer tendii r use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnanc	у		23d. Dat Mor	te of delivery nth Day Year	r
Ö.	e dea the at ned fo	Physician/Med	1 Yes 2 No	4□Pregnant at tir 9□Unknown	me of death 5[Other (specify)					
P.O.	The law requires that the death certifical tile has been signed by the attending phyage 2 should be detached for use as the		Part II. Other significant condition	e contributing to death but	not resulting in the u	ınderiving cause dı	en in Part I	23e. Did to	bacco use contr	nbute to the cause of death	 h?
	ires ti signe s be d	Completed by	Liztory		rote	middifymig dabbo giv		101	res 2 No	3 Probably 4 Unkn	nown
or O	neen	etec		/	V ((24a. Was	-	Were autopsy findings avai	ilahla
3ec	2 2	ם	- A Meroc	Scleroses				autop	rmed?	orior to completion of cause death?	e of
Vital Records,			OS War are referred to medical				00 Pl	1 Yes		I ☐ Yes 2 ☐ No	
₹	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 30 004 Ott	205	of Death (Check only o		er (Specify)	
ð	Phys or this oral di	 	27. Manner of Death	28a. Date of Injury	28b. Time o		-	-	now injury occurr		
<u>o</u>	Attanding r death. sctor: After by the fune	atio	1 Natural 5 Pending 2 Accident investiga		Year) Injury		Yes 2 □ N	0			
Division of	Atta actor by th	ific	3 Suicide 6 Could no 4 Homicide determin		y - At home, farm, st	reet, factory, office		28f. Location (S City or Tox	treet and Number, State)	er or Rural Route Number,	
	safter al Dira ed in b	Certification:		Sunday, oto.							
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical E	Physicien: To the best of xaminer: On the basis of e	xamination and/or in	th occurred at the ti	me, date and opinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)	
	To the l within 2. To tha I	Med	one) 29b. Signature and title of certifier	and manner state		29c. Licens	se number		29d. Date signer	d (Month, Day, Year)	
	To To To To To To To To To To To To To T		255. Signature and interor continer	MU		D 3	3138		Tamin	10 13 200	14
	4		20 Name of March	the completed serves of de-	ath (Itam 22a) (Turn	Print)	- 1 3	2	JUNIA.	1 1	
			30. Name and address of person w	Jaller MD	1950	o Ama	ranth	Arre 6	ermant.	own, MD	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1	,	Arive, G			
	Regist		JAN 14 2	2004 Sener	D	sparks					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 12, 2004 Marvin Samuel Underwood 6:00 p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Sunrise Assisted Living Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 12, 1911 Director 92 May Virginia 577-03-5104 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23s or 28s-f ehow event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12045 Valleywood Drive 20902 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 WWII 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hotel Personnel 4 Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumstic evonce. Thomas Underwood Mary Milstead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jackson/ Daughter 12231 Sleepy Horse Lane, Columbia, MD 21044 20b. Place of Disposition (Name of cometery, cramatory or other place)
Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State January 16 4 ☐ Donation 5 ☐ Other (Specify) Cematery 2004 Silver Spring, 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee J. Ken Stil 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease (COPD) obstructive pulmonary **Physician** Chronic 20 years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical NIA IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hypertension peq 1 Yes 2 No 3 Probably 4 Unknown Completed fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No W/A 24a. Was an autopsy performe NIA 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assited Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: in by the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D56531 Tan 15, 2004 0+1 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple Hickory Ridge Road, columbia, 10780 Harry Li, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1AN 16 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day7 Month Yea **Physician** JANUCE 17:45 2004 Vandegrift Benjamin Murray /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number, 4c. County of Death Examiner Prince Laures Legional Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Delaware 8. Date of Birth (Month, Day, 5. Social Security Number (In yrs. last birthday) **Funeral** Days 1 2 M 2 □ F 62 1, 221-26-0750 May Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28a-f show the Medical Examinar must be notified at Washington YE Yes 2 □ No D.C. None Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20007 2367 King Place, NW Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ⊠ Yes 2 □ Nol 962 — If Yes, Give Year or Dates: 1965 permit. Pagas 1 and 2 should be filed within 72 hours after. Department of Health and Mantal Hygiane. Important: If Item 27 is marked other than "neturel; or ite, eny Injury or other treumatic event, the Medical Exerciti 1 Never Married 2K Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Law Practice Attorney 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Jeannette Cameron Daniel Mitchell Vandegrift 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2367 King Place, NW., Washington, DC 20007 Barbara P. Vandegrift/Wife 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Jan. 10, 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State ALexandria, Va. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility De Vol Funeral Home 21. Signature of Funeral Service Licenses 2222 Wisconsin Ave., NW., Washington, DC 20007 vil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) a Arterioschertic Hyperterine Heart Disease //wedical Examiner Examiner the attanding physician and hed for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed been certificata has 1L Y .. 2 No 1 ☐ Yes 2 ☐ No I or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2ER/Outpatient 3□ DOA nours after daath.
neral Director: After this
y filled in by the funeral d 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1/ Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di complataly fillad in 1 Ceptifying Physicien: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Itagatal DNA SALVADA

Registrar

DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

JAN 13

2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

cm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

ysicia		Decedent's Name -	First, Middle.	tem#23a,Pa Last) Angel							-69-	2. Date of Deat Month January	Day	2004	3. Time of 8:50	Death P
/ledic	al	Angol 4a. Fecility Name (I				A R T SI			Town, or L	ocation o	of Death	January	1	ounty of Deeth		P
amin	er			Hospital					.lver					Montga		
eral		5. Social Security N		6. Sex	7. Age	(In yrs. las	st birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth			nlece (Stete o	r Fore
ctor		582-85- Usuel Residence of		1 ∑ M 2□F		23	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 5/02/	1980	Pue	rto R	
la d'ar	tor	10a. State Md	Montg	omery			Town or Lo								10d. Inside Ci 1 ☐ Yes	
avent, the Medical Examiner must be notified at	by Funeral Director	10e. Street and Nur 3203 B.		d Road				10f. Zip	Code 0895			1	0g. Citizer US	n of What Cou	intry?	
EME	eral	11. Marital Status		12. Was D		ever in U.S.	. 13.1	Was Deced	lent of His	panic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Amer		
Xa virac	by Fur	1 Never Marri		d 1 □Ye	Forces? es 2 ∑N Give or Dates:	lo	}	1⊠ Yes		Specify:			Sį	Black, White Decity: White		
SalE		/0	15. Decedent'	s Education	-		16a. Deced	tent's Usus	I Occupat	tion			16b. Kind	of Business/li	ndustry	
Med	Completed	Elementary/Seco		grade complete College	e (1-4or 5	+)		kind of wor			t of work	ing .	Fur	nitur	· a	
of, the		1 0 17. Father's Name	/First Middle I	acti			Up.	hols	_		ar's Name	e (First, Middle, I			-	
aumatic avent, the M	To Be	Angel '	Velazq	uez-So	to					Ar	lyn	Ivette	San	tiago		
r traum		19a. Informant's N										al Route Number Kensing				
or othe			Cremation	3 ☐Removal fro	om State	20b. Pla	ice of Disponetery, crer	sition (Name of the Name of th	ne of ther place buc	ca 1				tion - City or T	own, State uerto	Ri
any injury or other traumatic av		* 4 □ Donation 21. Signature of Fu		4.1		11011	22	Name an	d Address P D	of Facility	ALD	I FUNE	RAL	SERVI	CE,P.F	A .
4 Q		220 Part Foto	Delle	color the	at caused	the death						IVO Si		Spri	ng, Maz	
cian		23a. Part1. Ent at shock, or lead Immediate Cause disease or condition	(Final			ntoxic		01 1110 11100	o or dying.	, 50011 05	Jan Grado	or respiratory and	551,		Interval Bet Onset and I	weer
lical iner		resulting in death)	ence of):													
	Jer	Sequentially list co	nditions, nmediate	b. Due	to (or as a	a conseque	ence of):									
transi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ciscase or injury that initiated events resulting in death) Last														
he burial-transit	caj E)															
as the				T										3.41		
hed for use as the t	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2	! months? □ No	4□Pr	ve birth	of pregnan 2 Fetal o time of dea	death 3□	Ectopic pr					230	d. Date of deli-		Year
should be detached	by Ph	Part II. Dther signi	ficant conditio	ns contributing t	o death bu	ut not result	ting in the u	nderlying c	ause giver	n in Part I			_		the cause of d	•
pinor	ted	Head Injur	cies									1 🗆 Y	s 2 🗆 I	No 3∏Pro	bably 4 🖽	Jaka
CA	Completed											24a. Was a autops perform	ned?		opsy findings ompletion of c	
ctor.	Be	25. Was case refe examiner?	rred to medical	11 21		-					of Deat	h (Check only on	e)			
- Ta	은	1X Yes 2□			☐ Inpatie		R/Outpatier		A Other	4 140	irsing Ho	ome 5 Reside			ify)	
funer	tlon	27. Manner of Dea 1 ☐ Natural 2 ☐ Accident	n 5 ☐ Pending investig	four	ate of Injui Month, Day 1713/0	Yeer)	Injury unknowi		Work'	ai ? 'es 21∑	No	unknown	w injury c	ccurred		
completely filled in by the funer	27. Manner of Death 1 Natural 2 Natural 2 Natural 3 Suicide 4 Homicide 28a. Date of Injury (Mogth, Day Yeer) 1 Natural 3 Natural 3 Naticide 4 Homicide 28b. Inner of Death 1 North? 1 Natural 2 Natural 2 North? 1 Natural 2 North? 1 Natural 2 North? 1 Natural 2 North? 1 Natural 2 North? 1 Natural 2 North? 2 North? 2 North? 2 North? 2 North? 2 North? 2 North? 2 North? 2 North? 2 North? 3 North? 3 North? 4 North? 4 North? 4 North? 5 N										ral Route Num er Sprin	ber,				
itely filled	edical C	29a. Certifier (Check only one)	1 ☐ Certifyin 2 ☐ Medical I	exeminer: On the	the best of the basis of the basis of	examination	rledge, deat on and/or in	h occurred vestigation	at the time , in my opi	e, date ar inion, dea	nd place, ath occur	and due to the c red at the time, d	ause(s) ar ate and pl	nd manner as ace, and due	stated. to the cause(s	s)
tzi .	Med	29b. Signature and	title of certifier	<u></u>			^	290	. License	number		2	9d. Date s	signed (Month	, Day, Year)	
duo	,	1 (1)	-	()	-	-12	001		0.0	C.M.1	Ε.	J	ลกบลา	ry 14,	2004	
сошы		30. Name and add	rul	men	Me		020 T	Opins)	o//ev				ar, aa.	-1	2001	

Regis DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

1/6/04

VINEN, PRUL

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Marguerite Ann Volk 2004 January 8, /Medical 4c. County of Deeth 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Olney
If Under 1 Year If Under 24 Hrs. Montgomery General Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 🖫 F Yrs June 19,1924 Washington, D.C. Director 79 578-22-6278 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23a or 28a-f show important: or items 27a or 28a-f show an injury or other traumatic event, the Madical Examinat rough be trainfilled at ONGS. 1 Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2921 North Leisure World Blvd., #104 20906 USA 14. Race - American Indian, Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ۵ Specify: 3 € Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 US Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 William P. Carey <u>Julia E. Lipscomb</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Volk Daughter 8626 Savannah River Road Laure 1, Mary land 20 20c. Location - City or Town, Slate 20724 20b. Place of Disposition (Name of cometery, crematory or other place)
Resurrection
Cemetery 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Jan. 12, 2004 Clinton, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee memarie 500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis

Due to (or as a consequence of): disease or condition /Medical resulling in death) Examiner Pertorate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the attending physician and thed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ģ should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Ovarian Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? 1 Yes 2 No 2 \(\text{No} \) director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ч Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2€No 2 ER/Outpatient 3 DOA this 3 funejal 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1. Natural 1 Tyes 2 No 2 Accident **Director:** filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 0 Letrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Okindwood Ct. Olvey, god ARTHUR JA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 12** 2004 Registrar

	•	For State Registrar	State of Marylar	•	artment of H		Re	g. No.	6 02550
Physicia		1. Decedent's Name (First, Middle, Las John Va	n jda Way	ne			2. Date of Deat Month Jan 1	1 , ^{Day} 2004 ^{Υθα}	3. Time of Death 12:15р м
/Medic	al -	4e. Fecility Name (If not institution, give			4b. City, Town, or	r Location of D		4c. County of De	
LAdimii	C1	Washington Adv		oital		ma Par		Montgo	
Funeral Director		5. Social Security Number 6. Sec. 469-34-1775 11	2x	last birthday) Yrs.	If Under 1 Year Months Days		Ain. (Month, Dev.	Yeer) 9. 8 , 1921 C2	lirthplece (Stete or Foreign Country) zechoslovaki
show		10a. State 10b. County Md Montgo	_	ty. Town or Lo	Spring				10d. Inside City Limits 1 ☐ Yes 2 🖺 No
atural', or items 23a or 28a-f show ical Examiner must be notified at	Funeral Director	10e. Street and Number 11620 Kemp Mill	Road		10f. Zip Code 2090	2	1	0g. Citizen of What 0	Country?
ns 23	erai	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin	? (Specify Yes or No- uerto Rican, etc.)		nerican Indian,
Examiner	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1	-	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	sn, Mexican, Pi Specify:	u <i>er</i> to Hican, etc.)	Black, Wi	White White
Sical	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of	working	16b. Kind of Busines	ss/Industry
Ne Mu	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		entist	3)		Dental	
ic event, I	To Be Co	17. Father's Name (First, Middle, Last) Alexander Vajo					Name (First, Middle, I abeth Ste		
raumat	-	19a. Informant's Name/Relationship (r Rural Route Number	-	
othar traum		Allen Mushinsk	20b.	Place of Dispe	osition (Name of		the state of the s	20c. Location - City	
طڠ		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	cemetery, cre Chespe	matory or other place eake Cre	em. 1/	12/04 E	Beltsvil	le,Md
any injury or one		21. Signature Funeral Service Licy						AL SERVI ver Spri	CE,P.A. ng,Md20910
cian		23a. Pert1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	th. Do not en	ter the mode of dyir	ng, such as car	diac or respiratory are	9st,	Approximate Interval Between Onset and Death
lical iner		resulting in death)	Due to (or as a consex	quence of):	TRACK	INF	ECTO N		72095
ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Due to (or as a consec			_	D154+56		= YEARS
the burial-transit	Icai	resulting in death) Last			'E tte	AIST	FA) ILURE		= YEARS
tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date of o	delivery Day Year
d be de	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	underlying cause giv	ren in Part I.	23e. Did tol	_/ _	to the cause of death? Probably 4 Dunknown
shou	Completed						24a. Was a		autopsy findings available to completion of cause of
rector, page 2	Com						perform	med? death	?
rector.	Be	25. Was case referred to medical examiner?	Hospital:		Oth		Death (Check only on		
a d	-: To	1 Yes 2 No 27. Manner of Death	npatient 2L	ER/Outpatie		4 Nuisii	ng Home 5 Reside	ence 6 Other (S) ow injury occurred	pecify)
in by the funer	cation	1 Natural 5 Pending 2 Accident investigation		Injury	of 28c. Injur Wor M 1	rk? Yes 2 □ No		,	
ed in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, si ify)	reet, factory, office		City or Town		Rural Route Number,
completely filled	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, dea ation and/or i	th occurred at the time timestigation, in my o	me, date and popinion, death o	place, and due to the coccurred at the time, d	ause(s) and manner ate and place, and d	as stated. lue to the cause(s)
complet	Me	29b. Signature and title of certifier	78		29c. Licens			9d. Date signed (Mo	
		30. Name and address of person who	completed cause of death (the	m 23a) (Tuna	Print)	5292	-7 3	ANUARY	11th, 2004 PARK, MD
	-		_	M 23a) (1ype ASHTN	GTON A	DENTIS	T HOSPITAL	TACOMA	ARK, MD
Sta	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 4	long V	1			

		•	For State Registrar	State of	of Maryla		artment of H			giene Reg. No.	2004	02551
			Decedent's Name (First, Middle	Last)					2. Date of De			3. Time of Death
	hysici		Marion Joseph	Frank Wai	lker				Januar	y 6,	2004	11:00 AM
	/Medic Examin		4a. Fecility Name (If not institution,				4b. City, Town, o	Location of Death	1		County of Death	
		•	Holy Cross Hosp	ital			Silver S	pring		Mor	ntgomery	
Fı	uneral		5. Social Security Number	6. Sex	7. Age (In)	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	th y, Year)	9. Birthp	olece (State or Foreign
Di	rector		506-40-5597	1∭M 2□F	66	Yrs.	,		July 8	, 193	37 Nebra	ska
pur	2 4.50	1	Usuel Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	ocation				1	I Od. Inside City Limits
fanyle	sho	5	7.0									1X Yes 2 No
the N	28a-f	Director	DC none 10e. Street and Number		wa	shingtor	10f. Zip Code			10a. Citiz	en of What Cour	ntrv?
With	Pa or	ă		2			200	∩1		IIni+	ed State	
eath	na 23	Funerai	408 L Street #1	12. Was Dec	cedent Ever i	n U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No		4. Race - Americ	can Indian,
fter d	r then	F	1 ☑ Never Married 2 ☐ Marri	Armed F	2 💢 No		If Yes, specify Cuba	an, Mexican, Puen	o Rican, etc.)	1	Black, White,	etc.
S as	e o	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or			1 ☐ Yes 2 🔀 No	Specify:			Specify: Native	American
72 ho	natur	Completed	15. Decedent (Specify only highes	's Education	()	16a. Dece	dent's Usual Occup	ation during most of wor	rking	16b. Kin	d of Business/In	dustry
F ig .	Mes	npie	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired	1)				
ed withi	2	Co	8			Labore	er	18. Mother's Nar	no (Cirot Adidello		structio	· II
VICILIA Puld be file Mental Hy	even	Be	17. Father's Name (First, Middle, I								Sumame)	
y y o	natic	은	David Walker, J			10h Maili	ng Address (Street	Virginia			Tour State Zin	Code
Maryiariu Z.I.Z.13-0030 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.	7 ts n traun		19a. Informant's Name/Relationsh		0					-		
1 and Healt	ther	1	Jacqueline Hence	ierson -		b. Place of Dispo			Date Pat		1000000000000000000000000000000000000	
ages of of	Important: If item 27 is marked other than "natural", or items 23s or 28s-f show eny injury-or other traumatic event, the Medical Examinational be notified at once?		1X Burial 2 Cremation			•	matory or other place	4	0.01	Мост	NE	
Daltumor Dermit. Pages Department of	ar ED		 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service I 		- 00		ibal Ceme 2. Name and Addre			Macy		2
Depris	eny once		Manage	L.B.	201	1	l2 McCabe					
			23a. Pert1. Enter the disease shock, or heart failure.	complications that	caused the	leath. Do not en	ter the mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
Dhu	-1-1		Immediete Cause (Final									Onset and Death
	sician edícal		disease or condition resulting in death)			right :	Lung					days
Exa	miner	0		_{b.} Pneu	•	,						days
М.,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a con	sequence of):						
cuted	ndransit	Examine	that initiated events		r Fail							Years
e exe	ian ar ırial-t		resulting in death) Last			sequence of):						
8/0U,	physician and s the burial-transit	dicai		d. End	stage	renal d	isease					years
≨ و	ing pl	0	IF FEMALE:	00. 11								
death cer	or us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pre	Fetal death 3	Ectopic pregnancy	1		2	3d. Date of delive Month	ery Day Year
. eg	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk	gnant at time tnown	ordeath 51	Other (specify) _					
T at	been signed by the attending I should be detached for use as		Part II. Other significant condition	ns contributing to	death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to th	he cause of death?
Ords, P	sign d be	d by	-						1 🗆	Yes 2X	No 3 Prob	oably 4 Unknown
HECOLDS he law requires	peen	Completed							24a. Was	an	24b. Were auto	opsy findings available
Hec a law	has Je 2	m du							auto	psy ormed?	prior to co death?	impletion of cause of
_ =	certificate ha rector, page		OF Was seen referred to madical					os plana d Da	1 Yes	2 No	1 🗆 Yes	2 No
Of VITAL		o Be	25. Was case referred to medical examiner? 1 Yes 25/No		Inpatient	2 ER/Outpatie	ot 30 DOA Ott	100	ath (Check only		Other (Specif	60
o g		To To	27. Manner of Death	28a. Dat	e of Injury	28b. Time o			28d. Describe			7/
oding th	. Afte	atlo	1 Natural 5 Pendin 2 Accident investig	9	onth, Day Yea	r) Injury		Yes 2 □ No				
UIVISION I or Attending	ector by th	Hice	3 Suicide 6 Could determ	ined 288. Plat	ce of Injury -	At home, farm, st	reet, factory, office		28f. Location (City or To			al Route Number,
عَ الْحُوْدِ الْحُودِ الْحَادِ الْ	ig De	Certification:	4 [] Holliode	- Cui	iding, etc. (S)	ocny)				m, olulo,		
Hospit	To the Funerel Director: After the completely filled in by the funeral	edical (29a. Certifier 1 Certifyir (Check only one)	Examiner: On the	he best of my basis of exar	knowledge, dea mination and/or in	th occurred at the time timestigation, in my convertigation, in my convertigation.	me, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
o the	o the	Med	29b. Signature and title of certifie				29c. Licens	se number	Т	29d. Date	signed (Month,	Day, Year)
F 3	1		· Saim	1a 1	tron	was	D589	965		Janua	ary 7, 2	004
	1		30. Name and address of person	who completed ca	use of death	(Item 23a) (Type		, , , ,				
			Saima Khawja,			\ /		lver Spri	ing, MD	20910)	
36		ate	31. Date filed (Month, Day, Year)	32.	Registrar's S	ignature /	Spork					
is.	Regist	rar	JAN 14	ZUU4 /	(Lever		pour.					

		•	1 - For State Registrar AMEND#26perMD1	State of Marylar /21/04.BW.McCo			of Healt of Dea			giene Neg. No.	2004	02552
			Decedent's Name (First, Middle, Last)	,					2. Date of Dea		Vane	3. Time of Death
	Physicia		Michael Waris J	r.					Jan. 9,	2004	Year	10:00 AM
	/Medic Examin	_	4a. Fecility Name (If not institution, give s	treet and number)		4b. City, T	Town, or Locat	ion of Death	1	4c. C	ounty of Death	
			6707 Tusculum Road			Bethe					ntgome	
	Funeral		5. Social Security Number 6. Sex 195.14.8138	M 2□ F 7. Age (In yrs.		If Under 1 Months	Days Hou	rs Min.	8. Date of Birtl (Month, Day July 3,	Yeer)	Cou	place (State or Foreign ntry)
Д	Director		Usual Residence of Decedent	0.	<u>Z</u> 113.				July 3,	1921	Penn	sylvania
	iand ow		10a. State 10b. County		ty, Town or Lo							10d. Inside City Limits
	Mary -fah	Ş	MD Montgome	ry B	ethesda	а.						1 ☐ Yes 2√0XNo
	r 28s	irec	10e. Street and Number			10f. Zip (Code			10g. Citize	on of What Cou	ntry?
	th wit	Funeral Director	6707 Tusculum Roa	d			20817			U.	S.A.	
	ems erms	ner	TT. Marital Olatos	Was Decedent Ever in U Agreed Forces?	I.S. 13.	Was Decede	ent of Hispanio ify Cuban, Me	Origin? (S kican, Puert	pecify Yes or No- o Rican, etc.)	14	 Race - Ameri Black, White, 	
36	or th	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 A Yes 2 No If Yes, Give WW: Year or Dates: WW:	гт	1 ☐ Yes 2	No Spe	cify:		s	Specify: Wh:	ite
Ö	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tlems 23a or 28a-f ahow with the Medical Examiner must be riviffed at	pa pa	15. Decedent's Educ		,	dent's Usual	I Occupation				d of Business/Ir	
Ċ	in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work DO NOT use	k done during	most of wor	king			,
212	y with	E	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Atto	cney					Law	
פ	0 = 5	Be C	17. Father's Name (First, Middle, Last)				18. W		ne (First, Middle,		umame)	
12	should be and Mental are marked o	70 1	Michael Wari	s Sr.				Estl	ner Marc	h		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f ahow is marked other than "natural", or items 23a or 28a-f ahow aumatic event, the Madical Examiner must be rigitified at		19a. Informant's Name/Relationship (Type	•	19b. Maili	ng Address	(Street and Nu	ımber or Ru	ral Route Numbe	r, City or	Town, State, Zi,	o Code)
≥,	and ealth m 27		Mary Waris/ Wife				lum Ro	ad Be	ethesda,		20817	
ore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Re		Place of Disponentery, cre	matory or oti	her place)] 	Date		ation - City or T	
Ë	tant:		`4 □ Donation 5 □ Other (Specify)	31					seph Gaw			nnsylvania
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e one.		21. Signature of Funeral Service License	96					enue NW N			
	Fnysician	ar i	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the dea e cause on each line. Cerebrovas				h as cardiad	or respiratory ari	rest,		Approximate Interval Between Onset and Death 1 vear
	/Medical Examiner		resulting in death)	Due to (or as a consec Chronic De	mence of):			ovascı	ılar Dise	ease		5 years
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quanta of):							-
	ate be executed only sicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
8760,	oe exection sourial		resulting in doutiny saust	Due to (or as a consec	quence or);							
876	cate b	dica	d								- 31	
9 ×	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE:	3c. If yes, outcome of pregn	ancy					23	d. Date of deliv	erv.
Box	atten for u	cian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of	al death 3[□Ectopic pre □ Other (spe					Month	Day Year
P.O.	that the de ted by the a detached t	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			,,					
	es De	by	Part II. Other significant conditions con Prostate Carcino		sulting in the u	ınderlying ca	ause given in F	Part I.				the cause of death?
Records,	w requir been si should	Completed	Chronic Severe D	epression					24a. Was	20	24h Were auto	opsy findings available
Rec	The lay	du							autop perfor	sy med?	prior to co death?	empletion of cause of
	ician: Th certificate rector, pag	e C	25. Was case referred to medical				26.5	Place of Des	1 Yes	2X No	1 🗆 Yes	2 □ No
Vital	Physician: this certific al director,	0	examiner?	ospital:	ER/Outpatie	nt 3 DO	Othor		ome 5 Resid		□Other (Speci	(v)
0	Attending Physician: r death. sctor: After this certifics by the funeral director;	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		8c. Injury at Work?		28d. Describe h			,,
ō	ath. rr: After ne funer	atio	1XXNatural 5 ☐ Pending 2 ☐ Accident investigation	(momin, buy i our)	,,	М	1 Tes	2 🗌 No				
Division of	i ji te	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec		reet, factory,	, office		28f. Location (S City or Tow		Number or Rur	al Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Direction completely filled in	edical Co		sician: To the best of my kn ner: On the basis of examin and manner stated.								
	o the ithin is o the ample	Med	29b. Signature and title of certifier	and marrier stated.		29c.	. License num	ber		29d. Date	signed (Month,	Dey, Year)
	F 3 F 8		V V V V V	5/-			D23783	3	J	Tanua	ry 12,	2004
	5		30. Name and address of person who co					J. E	sposito,	MD		
	<u>-</u>		5530 Wisconsin		-		20815					
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature &	spo	uls!					

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12, 3:54 PM Robert William White January 2004 /Medical 4e. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1⊠M 2□F 276-16-2846 85 March 14, 1918 Tennessee Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or itams 23a or 28a-f show the Nedical Examinational be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20901 10804 Lombardy Road USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Infectionary if item 27 is marked other than "natural", or ital any injuryer other traumatic event, the Wedical Exertina once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 21 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Personnel Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ophelia Usery Henry White 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite Weaver/ Niece 10804 Lombardy Road, Silver Spring, MD 20b. Place of Disposition (Name of cometery, crematory or other place)
Evergreen
Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ⊠Removal from State Bedford Heights, OH * 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc. 21. Signature of Fyneral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the Sease, or complications that Cub of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Pancreatitis **Physician** /Medical Due to (or as a consequence of). Examiner Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Deep Venous Thrombosis the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Box 68760, Sepsis with Septic Shock Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 X No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 Division of Vital To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Late of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D58965 January 13, 2004 41 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 11119 Rockville Pike, #100, Rockville, MD 20852 Saima Khawaja M.D. 31. Date filed (Month, Day, Year) JAN 14 32. Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 9:50 PM Physician 11, 2004 January Emily Willauer R. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Potomac Montgomery Manor Care - Potomac 8. Date of Birth (Month, Day, Year) Dec. 26, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days **Funeral** Hours Min. 1 ☐ M 2 🖾 F 354-24-2864 95 Yrs. 1908 Missouri Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County il Hygiene. other than "natural", or items 23a or 28a-1 show vent, the Madical Examinar niust be notified at 1 X Yes 2 No Director Washington none 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20016 3951 Massachusetts Avenue United States death v Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours atter and of Health and Mental Hygiene. and if item 27 is marked other than "natural", or lie ary or other traumatic event, the Madical Examina 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by 3 NWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Dickinson Tarbell Thomas Nixon Rutter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other train Philip R. Willauer / Son 3951 Massachusetts Ave., Washington D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Date 20c. Location - City or Town, State 20a Method of Disposition January 13, 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Crematorium, Inc. Bethesda, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 2004 M01356 Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814-Pumphrey Funeral Home/ 7557 Wisconsin Avenue -3501 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia 10 days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 10 years Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any leading to immediate Due to (or as a consequence of) if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit and Due to (or as a consequence of) P.O. Box 68760, death certificate be Physician/Medical as the t IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 □Ectopic pregnancy Year ŏ in the past 12 months? Month Day 5 Other (specify) ☐ Yes 2 2 No the detached 9 Unknown 9 Hinknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No 1 Yes 2 X No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 🛮 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 2 ER/Outpatient 1 Yes 2 No 1 🗌 Inpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation Injury 1 ANatural 1 ☐ Yes 2 ☐ No o the Hospital or Attendirithin 24 hours after death.

o the Funeral Director; A death. 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2 rathanM January 12, 2004 D0053615 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 Rockville Pike, Rockville, Maryland Aruna Nathan, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State souks JAN 14 2004 Registrar

			For Stete Registrar	• •	ryland / Der		nt of H	ealth and I	-		_	02555	
			Decedent's Name (First, Middle, Last)						2. Date of D	eath		3. Time of Death	
	Physicia /Medic		Wilma A. Wilson			4h Cin	Tour	Location of Death	Januar			8:00 A M	
	Examin	er	4a. Facility Name (If not institution, give s						!		•		
			Shady Grove Advent: 5. Social Security Number 6. Sex		tal (In yrs. last birthda		cvill	e If Under 24 Hrs.	8. Date of Bi	rth.	ntgomery 9. Birth		
e i	Funeral Director		174-32 - 7539	M 2X) F	64 Yrs.	Months		Hours Min.	May 9,	ay, Year)	Penn	place (State or Foreign ntry) ISYlvania	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits	
	daryl f sho	ō	Maryland Montgomery	.,	Germanto							1 ☐ Yes 2 📉 No	
	158 288 BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB	Director	10e. Street and Number	у	GCIMANEO		p Code			10g. Citi	zen of What Cou	ntry?	
	3a or	iD	13262 Country Ridge	e Drive			20	874		Un:	ited Sta	tes	
	death ms 2	Funerai		12. Was Decedent B	Ever in U.S. 13	3. Was Dece	dent of Hi	spanic Origin? (S n, Mexican, Puert	pecify Yes or N	0-	14. Race - Ameri		
۵	or Ite	Ψ̈́	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 N If Yes, Give	lo	1 Yes			o nicari, etc.)		Black, White,		
3	ral', c	l by	3X Widowed 4 □ Divorced	Year or Dates:		1 162	21A 140	эреспу.			Specify: Bla	ck	
ה ה	72 h	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dec	edent's Usu ve kind of wo	al Occupa	ation fu <i>ring most of wor</i>)	king	16b. Ki	nd of Business/Ir	ndustry	
7	Athin han	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+))		Λ.	11000000		
7	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23s or 28e-f show ent, the Medical Execution must be notified at	ပိ	17. Father's Name (First, Middle, Last)	4	Soci	al Wor	rker	18. Mother's Nan	ne (First Middle	_	llegheny		
פער	htal h	Be						_		o, <i>m</i> aaaan	Jamaino,		
Ž	d Mei d Mei nark	ဥ	David Gibson 19a. Informant's Name/Relationship (Ty)	na Print)	19h Ma	ilina Addres		Ann Tayl and Number or Ru		her City o	r Town State Zi	n Code)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Items 23a or 28e-f show many intry or other traumatic event, the Medical Effect instruct the notified at once.		Alesia Wilson/Daugh			•		Ridge Dr					
_ o	1 an Heali em 2		20a. Method of Disposition	ircer	20b. Place of Dis	position /Na	me of		Date Det		cation - City or T		
Baitimore,	No II of		1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	Jefferso	rematory or o N	other plac	^{e)} .Ian 1	7. 2004	Pitt	tsburgh.	PΑ	
	artme ortan injury		1 MBurial 2 Cremation 3 Removal from State Jefferson Memorial Jan 17, 2004 Pittsburgh, PA 21. Signature of Funeral Service Aicensee CC 0321 22. Name and Address of FacilityWhite Memorial Chapel										
n G	permit Depar Impor any ir		Manarely	Basia				s Blvd.,			-	.08	
ój:			23a. Part1. Enter the dispase, or compliant shock, or heart faire, list only or	cations that caused	the death. Do not e	nter the mo	de of dyin	g, such as cardiad	or respiratory	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Fig.1									Onset and Death	
4	/Medical		disease or condition resulting in death)		tic Cance a consequence of):	r						6 months	
	Examiner												
e V		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):								
	ite be executed sysicien and ne burial-transit	Examiner	that initiated events										
760,	e exe ien al		resulting in death) Last	Due to (or as	a consequence of):								
376	ate be hysici the bu	lical		1									
89 ×	death certificate e attending phy ed for use as the	by Physician/Medi	IF FEMALÉ:	2- 15	-4								
Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic p				1	23d. Date of deliv Month	ery Day Year	
o.	0 0 0	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death :	5 ☐ Other (s	рөспу)						
о_	The law requires that the de ate has been signed by the r page 2 should be detached	P	Part II, Other significant conditions con	ntributing to death be	ut not resulting in the	underlying	cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?	
ds,	sign d be								1 🗆	Yes 2	X No 3 □ Pro	bably 4 Unknown	
Vital Record	v requ	Completed							24a. Wa	s an	24h Were aut	opsy findings available	
Re	8 6	E G							auto	opsy formed?	prior to co death?	ompletion of cause of	
			OF Man case referred to madical					00 Bl/ B	1 Yes		1 Tes	2 No	
Ĭ		Be c	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum XNo	lospital: 1 XInpatie	nt 2□ER/Outpat	ient 3 D	Othe	26. Place of Dea			6 □Other (Speci	(f.)	
o	Phys ir this aral di	. To	27. Manner of Death	28a. Date of Injui		of	28c. Injury	at	28d. Describe			197	
0	ding th. : Afte	iệ.	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	Year) Injury	м	Worl	(? Yes 2 □ No					
Division	Attending r death.	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju-	ury - At home, farm,	street, factor	ry, office			(Street an		al Route Number,	
Ö	s after s after al Dire	Certification;	Tiomicide	ballaling, etc	J. (Opecity)				J., J., J.		,		
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funaral Director: After the completely filled in by the funeral	edicai	29a. Certifier 1 X Certifying Physical Check only one)		examination and/or								
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License	number		29d. Dat	e signed (Month,	Day, Year)	
	7		1 HAR	/	1	110		D5868	31	Ja	nuary 9,	2004	
	(30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Typ	e, Print)		- :: -					
			Jude R. Alexander,			1 Cen	ter I	rive, Ro	ckville	, MD	20850		
	s Sta Regist	ate	31. Date filed (<i>Month, Day,</i> Year) IAN 1 4 200	2	ar's Signature	lo	arks						

				State of Maryland		artment of rtificate of			iene 2 (Control of the Contro	02556
	Dhyaisi		1. Decedent's Name (First, Middle, L	.est)				2. Date of Deat Month	h Day	Year	3. Time of Death
4.	Physici /Medio		NORMA F.	WINDSOR				January		:004	1:55 AM
	Examir		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of Death	4c. County	y of Death	
			Edward W. McCrea				Crisfi			merse	et
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. In 1		If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign ntry)
	Director		219-01-6778	8	8 Yrs.			August 2		5 Ma	aryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or L	ocation				1	0d. Inside City Limits
	daryl f sho	5			,		61 33				1⊠ Yes 2□ No
	the 1	Directo	Maryland Some	rset		10f. Zip Code	sfield	1	0g. Citizen of	What Cour	ntn/?
	A S					1011 210 0000	21017		_		му.
	ns 2	Funerai	201 Gandy Lane	12. Was Decedent Ever in U,S	S. 13.	Was Decedent of	21817 Hispanic Orlgin? (S	Specify Yes or No-		USA ce - Americ	an Indian.
	riter	듄	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cub	oan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Bla	ck, White,	etc.
ž	urs a		3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1⊡ Yes 2⊠ No	Specify:		Specif	y: Whi	ite
<u>ک</u>	be filed within 72 hours after death with the Marylan tal Hygiene. tal Hygiene. tother then "neturel; or items 23a or 28e-f show event, the Madical Examiner mast be notified at	Completed by	15. Decedent's 8	Education	16a. Dece	dent's Usual Occu	pation	file.	16b. Kind of B	usiness/Ind	dustry
Š	thin 7	pie	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of wo	orking			
7	er the	5	12			Clerk			five a	ınd di	me store
פ	a dig	Be	17. Father's Name (First, Middle, Las	st)			18. Mother's Na	me (First, Middle, M	Maiden Suman	ne)	
<u>~</u>	Men Men arkec	၉	Harlan K. Sterlin				Georgia	Lawson			
Maryland 21215-0020	2 sh and is ma	. 4	19a. Informant's Name/Relationship			_		ural Route Number			•
<u>~</u>	ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If the strain and Second the then "neture!" or items 23a or 28e-f show other traumatic event, If the Macifical Examiner must be inclified at		Sandra J. Windson					sfield, Ma			
0	or off		20a. Method of Disposition 1 Burial 2 □ Cremation 3	20b. Pla Ce Removal from State	ace of Dispo metery, cre	osition (Name of matory or other pla	ice)	Date	20c. Location	· City or To	wn, State
	ment ment ant: ury c		4 ☐ Donation 5 ☐ Other (Spec	ify) Sunr	yridg	e Memori	al Park	1/30/04 C	risfie	ld, M	aryland
Baitimore,	permit. Pages I Department of I- Important: If Ite eny Injury or ot	E E	21. Signature of Funeral Services Lice	Bookak Tadshaw-Pruitt	#-B		& Sons Fi	uneral Ho		Marcal	and 21817_
			23a. Part1. Enter the disease, or conshock, or heart failure. List only		. Do not en	ter the <i>m</i> ode of dyi	ng, such as cardia	c or respiratory arre	st,	Maryı	Approximate
N. F	Physician		snock, or neart failure. List only	y one cause on each line.						į	Interval Between Onset and Death
<i>)</i>	/Medical		Immediate Cause (Final disease or condition		A	SCVD				1	
	Examiner		resulting in death)	a Due to (or	as a consec					-	
	р ≃	le l								}	
	acute ind trans	Examiner	Sequentially list conditions,	Due to (or	as a consec	quence of):					
ຂົ	e exe	û	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							1	
09/8	requires that the death certificate be executed the signed by the attending physician and hould be detached for use as the burial-transit	dical	that initiated events resulting in death) Last	Due to (or	as a conseq	uence of):					
٥	ing p	a u I									
Š į	ath or trend or us	Physician/M		d.						1	- Ferritain
5	e de the a	sic	Part II. Other significant conditions	contributing to death but not resul	ting in the u	nderlying cause gi	ven in Part I.	23b. Did tol	bacco use co	ntribute to	the cause of death?
	d by letacl							1 □ Ye	s 20 No	3 🗌 Prob	ably 4 Unknown
ģ.	igne be d	<u>م</u>		<u>.</u>				-		T	
cords,	plnor	Completed						24a. Was ar perfor <i>n</i>		ava	re autopsy findings illable prior to
ည် ည	as by	ed									mpletion of cause leath?
ב -	ate h	5						1 □ Ye	s 200 No	1□]Yes 2□ No
<u> </u>	artifica ctor,	Be (25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one)		
5	nysic lis ce	2	1 Yes 2 XNo	Hospital: 1 Minpatient 2□ E	R/Outpatier	t 3□ DOA Oth	ner: 4 🗆 Nursing H	lo <i>m</i> e 5□ Reside	nce 6 □Oth	er (Specify)
5 Z	ter th		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe ho	w injury occurr	ed	
VISION	or: Af	atic	2 Accident investigation	on			Yes 2 □ No				
<u> </u>	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,
5	rs aft	Se		3, (),							:
1	To the respital of Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only 2 Medical Exa	hysician: To the best of my know miner: On the basis of examination	ledge, death on and/or inv	occurred at the tive	me, date and place	e, and due to the ca	use(s) and ma te and place. a	nner as sta	ated. the cause(s)
-	the t	Med	(ITE)	and manner stated.							
. 7	- ¥ 6 0		29b. Signature and title of certifier	10 100		29c. Licens	e nu <i>m</i> ber > 4809	i	d. Date signed	- 1 -	3
				V (1 0)			4001	0	1/2	7/0	4
	0		30. Name and address of person who								
	4		Vijay Karumbunat			Highway	- Crisfi	ield, Mar	yland 2	21817	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	le la	A. a. N. a	7				

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month 00 4 M **Physician** 2004 LIZABETH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. | a r 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M A F Yrs. Mar Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State r items 23a or 28e-1 show drer cust be notified at 1 Yes No Funeral Directo 00 Mary/and 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Coad filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11 Marital Status 1 Never Married 2 Married 5 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: ò 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) perator 12 lelephone Department of Health and Mental Hygie Importent: If item 27 Is marked other any injury or other treumatic event, II ODGS. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ္ tor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) avred Grace No 2102 Webst oab Lendy L daughter 19 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee he and Address of Facility 9.8 30 21001 57 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of) use as the burial-Division of Vital Records, P.O. Box 6876 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month After this certificate has been signed by the atte funeral director, page 2 should be detached for in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 21 No 1 ☐ Yes Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 3 No 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 0 2004

So,

	1 - For State of Mary	and / Department of H Certificate of I	lealth and Mental Hygie Death Reg.	
	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
Physician /Medical	FLORENCE W. YANT		Danuar	1 1 2 - 1 0 14
Examiner	4a. Fecility Name (If not institution, give street and number)	,		4c. County of Death
	PENINSULA REGIONAL MEDICAL		12/364/1	NICOMICO
Funeral	5. Social Security Number 6. Sex 7. Age (In 1	yrs. last birthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye O1 / 1.9 / 1	9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent		01/15/1	934 Virginia
ylanc	10a. State 10b. County 10c	City, Town or Location		10d. Inside City Limits
the Marylan 28a-f show motified at	VA Accomack	Parksley		1 ☐ Yes 2 ŽÑNo
ath with the Maryla 23e or 28e-f sho ust be ruddiled at	10e. Street and Number	10f. Zip Code		. Citizen of What Country?
16 after death with the Ma or items 23s or 28s-fs critise frings be notified Funeral Director	26365 Dennis Dr. 11 Marital Status 12. Was Decedent Ever	2342		USA 14. Race - American Indian,
item Inerr	11. Marital Status 12. Was Decedent Ever Armed Forces? 1 □ Never Married 2 □ Marned 11. □ Yes 2 □ No	If Yes, specify Cuba	ispanic Origin? (Specify Yes or No- in, Mexican, Puerto Rican, etc.)	Black, White, etc.
036 urs a	3 DWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2√2 No	Specify:	Specify: Black
:1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show fre Muclical Exercitive relations to the modified at ampleted by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation 16th	b. Kind of Business/Industry
m plan	4 Elementary/Secondary (0·12) College (1-4or 5+)		D	
Hygie V	17. Father's Name (First, Middle, Last)	Housewife	18. Mother's Name (First, Middle, Mai	Home
Maryland 21215-00 Lashould be lited within 72 houn and Mental Hygiene. Tis marked other than "naturarraumatic event, the Medical Enaumatic event event event event event event event event event event event event	Alfred C. White		Elizabeth Downi	
Shoul nd Mark	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street a	and Number or Rural Route Number, Co	
Me, Me	Arthur P. Yant, Son	8653 Greenbel	lt Rd., Greenbelt,	MD 20770
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be lifed within 72 hours alt partment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural, or yinjury or other traumatic event, the Medical Exertice. To Be Completed by F	20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State	b. Place of Disposition (Name of cemetery, crematory or other place	Date 20d	c. Location - City or Town, State
im Pag	'4 □Donation 5 □Other (Speghy)	First Baptist Cen		Mappsville, VA
Baltimore, Maryland 212 Baltimore, Maryland 212 permit. Pages 1 and 2 should be lifed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item once. To Be Comp	21. Signature of Funeral Wick IV ns	22. Name and Address	ss of Facility Humbles Funeral Co	., Accomac, VA
	23a Part 1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line.	death. Do not enter the mode of dying	g, such as cardiac or respiratory arrest,	Interval Between
Physician	Immediate Cause (Final disease or condition			Onset and Death
/Medical Examiner	resulting in death) Due to (or as a cor			
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cor			
mlne	cause. Enter Underlying Cause (Disease or injury	soquotico oty.		
760, 1 be executed sician and burial-transit	that intrieted events c	sequence of):		
8760, sate be ex by by sician at the burial	d			
r 68 ortifica ing ph	IF FEMALE:			
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	23b. Was decedent pregnant 1 Live birth 2	Fetal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
O. I he de the a	1 Yes 2 No 9 Unknown 9 Unknown	of death 5 Other (specify)		
cords, P.O. wrequires that the dipensioned by the should be detached	Part II. Other significent conditions contributing to death but no	resulting in the underlying cause give	en in Part I. 23e. Did tobac	co use contribute to the cause of death?
rds, F luires tha n signed and be del	BENA L FAILY	KC	1 ☐ Yes	2 No 3 Probably 4 Unknown
Il Records, The law requires to cate has been signe page 2 should be completed by			24a. Was an	24b. Were autopsy findings available
Vital Recomp			autopsy performed 1 □ Yes 2 □	
	25. Was case referred to medical examiner?		26. Place of Death (Check only one)	
of V Physic this ce al dire	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient 3 ☐ DOA Othe	4 Nursing Home 5 Nesidence	
Division of Vital Records, or Attending Physicien: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Yea			injury occurred
ision ttendir death. ctor: Af y the fu	2 Accident investigation 3 Suicide 6 Could not be	At home, farm, street, factory, office	Yes 2 □No	at and Number or Rural Route Number,
Division C tel or Attending P is after death. at Director; After I led in by the funer? Certification:	4 Homicide determined building, etc. (S)	pecify)	City or Town, S	State)
S S S S S	29a. Certifier 1 Certifying Physician: To the best of my			
he Hosp in 24 hou he Fune pietely fil edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or investigation, in my op	oinion, death occurred at the time, date	and place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	29c. License	number 29d.	Date signed (Month, Day, Year)
	PA & Syrdnush	020	1912	1-13-07
CHO	30. Name and a ress of person who completed cause of death	(Item 23a) (Type, Print)	- 1 Salvi	100 1 11:52 = ==
O I I I A	Dennis Chodnicki Ferrins 31. Date filed (Month, Day, Year) 32. Registrar's S	ignature	enter Allisbur	1) Ma. 21802
State Registrar	31. Date filed (Month, Day, Year) 32. (legistrar's S	It spents	1912 Center Salisbur)

			1 - State Registrar	tate of Marylan		rtment of H		nd Menta		ene 20	04	02559
	Dhysisi		Decedent's Name (First, Middle, Last)					2. Dat	e of Death	Day Y	'eer	3. Time of Death
	Physici: /Medic		Edward Charles E					Janu		23, 2004		3:00 a M
	Examin	er	4a. Fecility Name (If not institution, give stree	_		4b. City, Town, or		Death		4c. County of		
			3177 Rolling Roa 5. Social Security Number 6. Sex	7. Age (In yrs. I	ast hirthday)	Edgewate	If Under 2	4 Hrs. A Dat	e of Birth			Arundel ace (State or Foreign
	Funeral Director		216–18–4226			Months Days	Hours		nth. Day, Y	1925	Coun	yland
			Usuat Residence of Decedent							· · · · · · · · · · · · · · · · · · ·		
	rylan how		10a. State 10b. County	10c. City	, Town or Lo						10	Od. Inside City Limits
	Ba-f a	cto	Maryland Worcester		0c	ean City						1 ☐ Yes 2 ☐ No
	with th	Dire	10e. Street and Number 235 25th Street			10f. Zip Code 21842			100	g. Citizen of Wh United		•
	9 23 c	by Funeral Director		Was Decedent Ever in U.	S 12 1		spanic Origi	in? (Specify Ve	s or No-	14. Race -		
10	ter d	Fun	The state of the s	Armed Forces?	3.	Vas Decedent of His f Yes, specify Cubar	n, Mexican,	Puerto Rican,	etc.)		White,	etc.
980	urs al	by	2.0	f Yes, Give Year or Dates:	1	I□Yes 212 No	Specify:			Specify:	W	nite
21215-0036	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ahow disal Examilien and be molified at	Completed	15. Decedent's Education (Specify only highest grade columns)		16a. Deced	lent's Usual Occupa	ition Jurina most	of working	16	6b. Kind of Busi	ness/Ind	ustry
21	han han	id m	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired)						
2	Hygie Ther t	ပိ	12 17. Father's Name (First, Middle, Last)		Fire	Protectio				'ire Pro	tect	ion
and	d be f	o Be	Charles Balinsky					Margare				
Maryland	Shouli nd Me mark	ဥ	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a					ate, Zip	Code)
	s 1 and 2 of Health a item 27 is other trau		Edward C. Balinsky,	Jr Son	3177	Rolling R	Road,	Edgewat	er, M	aryland	210)37
ore,	of He of He rothe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Remo	wal from State	emetery, cren	sition (Name of natory or other place		Date		c. Location · Ci		
Ĕ	Page ment: It		'4 □ Denation 5 □ Other (Specify)	Lou		rk Cemete					•	_
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than *natural; or iteme 23a or 28a-f ahow amortant: quiry or other traumatic event, I'm Mudical Exaturiar initial be notified at ORCs.		21. Signature of Juneral Service Nicensee	Sinder		Name and Address 107 Wilke					•	
ľ			23a. Part : Enter the disease, or complication shock, or heart failure. List only one can	ons that caused the death	n. Do not ente	er the mode of dying	g, such as ca	ardiac or respir	atory arres	t,		Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition	Esophageal	Cancer						4	vears
	/Medical Examiner		resulting in death)	Due to (or as a consequ								1
Ė		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):							· · · · · · · · · · · · · · · · · · ·
	uted d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c									
ó	exectan and rial-tra	Еха	resulting in death) Last	Due to (or as a consequ	uence of):							
8760,	Taw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	icai	d									
9	e as t	Med	IF FEMALE:			-						
Вох	eath certific attending pl	lan/	n the past 12 months?	If yes, outcome of pregna 1☐ Live birth 2☐ Fetal	death 3	Ectopic pregnancy				23d. Date of Month		ry Day Year
P.O.	that the de ed by the a detached	Physician/M		4□Pregnant at time of di 9□Unknown	eath 5	Other (specify)						
	res that the igned by be detact		Part II. Other significant conditions contrib	uting to death but not resi	ulting in the ur	nderlying cause give	n in Part I.	23	e. Did toba	cco use contrib	ute to th	e cause of death?
Records,	quires n sign	ed by	Asbestosis						1 🗌 Yes	2 🛮 No 3	☐ Proba	ably 4 □Unknown
00	law requii as been s 2 should	Completed	Coronary Artery Dise	2256				24	a. Was an	24b. We	re autor	sy findings available
Ä	9 5 9	E	Rheumatoid Arthritis						autopsy performe Yes 2X	d? dea	ith?	2□ No
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					of Death (Chec	k only one)			nont.
2 <	Physician: this certificated director,	2	1 ☐ Yes 2 ☑ No Hosp	1 Linpatient 2 Li			4 14013			ce 6X1Other		Son's Residence
N C		lon:	1 portational o a condition	8a. Date of Injury (Month, Day Year)	28b. Time of tnjury	28c. Injury Work M 1 ☐ Y	rat ⊘? ∕es 2.⊟N		scribe how	injury occurred		
Division of Vital	e at a se	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	Be. Place of trijury - At ho	me, farm, str		163 2 11		ation (Stre	et and Number	or Rural	Route Number,
Ö	after Dire d in b	Certification;	4 Homicide	building, etc. (Specify	1)	, , , , , , , , , , , , , , , , , , , ,		City	or Town,	State)		
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	ledical ((Check only 2 Medical Examiner:	in: To the best of my kno On the basis of examina and manner stated.								
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License			290	J. Date signed (Month, L	Day, Year)
	\/\		Rome Dan	100		D4133	9			1/23/0	9	
	1011		30. Name and address of person who compl							1		
	/ -		Jamie Harms, MD 130	Jove Point 32. Registrar's Signa		Stevensv	ille,	Maryla	nd 21	666		
	Sta Registr		FFB 0 2 200			horte)						

DHMH 17 Rev 1/2001

ORIGINAL

			Please Typ					Ensure A				le.	
		•	For State Registrar		,	•	tificate of			Reg. No	Ω	04	02560
			Decedent's Name (First, Middle, Last)						2. Date of De	eath			3. Time of Death
	Physicia		Madeline Helen Batze	j					Januar	y 2		Year 94	10:35 PM
	/Medic Examin		4a. Fecility Name (If not institution, give stree				4b City, Town, o	r Location of Death		/ 1	County o	f Death	L.
	<u> </u>		Manokin Manor				Trince		e		om		set
П	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last i		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Sept 3	rth ay, Year			lace (State or Foreign ntry)
	Director		218-05-9295	ZIAIF	86	Yrs.			Sept 3	, 19	17	Mary	land
	and *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	cation					1	0d. Inside City Limits
	Aaryli f sho	ច	Maryland Somerset		Princ	ress	Anne						1 ☐ Yes 2 🔯 No
	ith the Marylan or 28a-f show	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of W	hat Cour	ntry?
	death with the Maryland ms 23e or 28a-f show rmust be mulified at		11974 Edgehill Terra	CO			21853			Т	Jnite	a st	ates
	death	Funerai	11 Marital Status 12. V	Was Decedent Ev	rer in U.S.	13. V	Vas Decedent of I	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or N		14. Race		an Indian,
	or Ite		1 Never Married 2 Married	Armed Forces? 1			☐ Yes 212 No	Specify:	rilouri, oto.)		Specify:		ite
3	72 hours after natural', or Ite dical Exemine	d b	3 X Widowed 4 □ Divorced	Year or Dates:									
'n	72 h 'natu dical	ete	15. Decedent's Education (Specify only highest grade co	on mpleted)	16	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of wor.	king	16b. F	(ind of Bus	siness/In	dustry
7	swithin 72 hours after death with the Maryla liene. Trhan "natural", or liems 23e or 28a-1 shov The Madical Examiner must Le modified at	Completed		College (1-4or 5+)		Clerk	0)			Drug	Sto	re
7	Hygie Hygie ther i		17. Father's Name (First, Middle, Last))				18. Mother's Nan	ne (First, Middle	e, Maidei			
a a	lid be lental ked o	To Be	Frank Sieg					Louise K	Gerner				
<u>-</u>	2 should and Mer is marke aumatic	Ĕ	19a. Informant's Name/Relationship (Type,	Print)	1	9b. Mailin	g Address (Street	and Number or Ru		ber, City	or Town, S	State, Zip	Code)
Z Z	trais		Lula Grace - daughte	er	3	026	Janice A	venue, Ba	ltimore	e, Ma	aryla	nd 2	1230
ē,	ーゴるを		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other pla	(ce)	Date	20c. L	ocation - (City or To	own, State
Ē	o o = >		1 to Burial 2 ☐ Cremation 3 ☐ Remo 3 ☐ Donation 5 ☐ Other (Specify)	oval from State	1	•		· I	31 . 2004	Ba	ltimo	re.	Maryland
a	nit.		21. Signature of Funeral Service Licensee	ſ	LOUG	22	. Name and Addre	ery Jan ess of FacilityHub	bard Fu	mera	al Ho	me,	Inc.
ă	Pen Impo		Ilm Jun								e, M	aryl	and 21229
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are shocked to the shock of the sho	ons that caused t ause on each line	he death. D	o not ente	er the mode of dyi	ng, such as cardiad	or respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition										2 0/43
	/Medical		resulting in death)	Due to (or as a	consequen	ce of):	COLITIS ASWO						
	Examiner	L	Sequentially list conditions, b				ASWO						sycens
	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or as a	consequen	ce oi):							
	executed in and ial-transit	Examin	that initiated events c resulting in death) Last	Due to (or as a	consequen	ce of):							
၌		_		,									
Box 68/6	The law requires that the death certificate be eate has been signed by the attending physicial page 2 should be detached for use as the buri	by Physician/Medical	0										
×	eath certific attending pl	Z/M	IF FEMALE: 23c.	If yes, outcome of						-	23d. Date	of deliv	ery
ň	d for	iciai	in the past 12 months?	1☐Live birth 2 4☐Pregnant at t]Ectopic pregnand] Other (s <i>pecify)</i> _	;y 			Mon	ith	Day Year
J.	oy the	hys	9 Unknown	9□ Unknown									
	res that the de signed by the a l be detached f	y P	Part II. Other significant conditions contrib	outing to death bu	t not resultin	g in the u	nderlying cause gr	ven in Part I.	- 1				he cause of death?
ğ	w require been sig should b								1 [Yes 2	No No	3 Prol	oably 4 Unknown
င္တ	awre is ber 2 sho	Completed					,		24a. Wa aut	opsv	p	rior to co	ppsy findings available impletion of cause of
ř	The late had page	E O							per 1 □ Yes	formed?		eath? □ Yes	2 □ No
Ita	ian: artifica ctor, I	Bec	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	r one)			
<u>></u>	hysic his ce Il dire	ျ	1 ☐ Yes 2 ☑ No	1 Unpatier			I 3 DOA		lome 5 Re				(y)
ב	ing P Viter t unera	on:	i Elitatulai 5 1 oliding	28a. Date of Injun (Month, Day	Year) 28	b. Time of Injury	Wo	ıryat ork? ∐Yes 2∐No	28d. Describe	o now inji	ury occurre	90	
Sio	tandi leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	on - Diese of John	a. Athema	- form			28f Location	(Street s	and Numbe	r or Run	al Route Number,
Division of Vital Records,	or At fiter d Sirect in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At nome . <i>(Specify)</i>	, rarm, str	eet, factory, office	•		own, Sta		or Hur	ar riodio riombor,
	pitel ours a eral (29a. Certifier 1 Certifying Physici	en: To the best o	f my knowle	dge, deat	h occurred at the t	ime, date and place	and due to th	e cause(s) and mar	nner as s	stated.
	To the Hospitel or Attending Physicien: The law within Z4 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examiner one)		examination								
	o the	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. D	ate signed	(Month,	Day, Year)
	- s + ō		29b. Signature and title of certifier				Do	51359		Jan	~ 29	15 5	2004
	3		30. Name and address of person who comp	eleted cause of de	eath (Item 23	la) (Type,							
	3							702180	4				
	Sta		1415 - S - D/V/S 31. Date filed (Month, Day, Year) FEB 0 2	32. Registra	s Signature	14	And	ĝ	1				
	Regist	rar	LER 02	2004	G Below	Section Section	Page 1						

00788		Please	Otata of Manda									
		1 - For State Registrar	State of Maryla		artment of H rtificate of I		Re	g. No. 2004 02561				
Physic /Medi		1. Decedent's Name (First, Middle, Last James A. Broadnax	, Jr.				2. Date of Death Month January	28, 2004 709 P M				
Examir	ner	4a. Facility Name (If not institution, give 5983 Tyler Road	street and number)		4b. City, Town, or Deale	Location of Death	1	Anne Arundel				
Funeral Director			x 7. Age (In yrs	: last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Aug. 12, 1	year) 962 9. Birthplace (State or Foreign Country) Washington, D.C				
e Maryland is-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Art		ity, Town or Lo	ocation			10d. Inside City Limits 1 ☐ Yes ※☐ No				
h with th	ai Director	10e. Street and Number 5983 Tyler Road			10f. Zip Code 2076	1	10	10g. Citizen of What Country? United States				
21215-UU36 Jwithin 72 hours after death with the Maryland Jione. r than "natural", or items 23a or 28s-f show The Medical Evaninar must be notified at	by Funerai	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 XXo	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- Dican, etc.)	14. Race · American Indian, Black, White, etc. Specify: Black				
VITID-UU36 within 72 hours aft ene. than "natural; or the Medical Exami	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of wor)	king 1	6b. Kind of Business/Industry				
be filed that Hyge of other event,	To Be Con	12 17. Father's Name (First, Middle, Last) James A. Broadnax.	2	Foren	nan	18. Mother's Nan Barbara	ne (First, Middle, M	Marina laiden Sumame)				
Mary nd 2 sho lith and 1 27 is me		19a. Informant's Name/Relationship (7) Barbara Broadnax/N			ng Address (Street a			City or Town, State, Zip Code) 61				
Saltimore, bernit. Pages 1 ar Department of Hea mportant: If Item any injury or othe		20a. Method of Disposition 1 Burial 2	Removal from State	cemetery, crei	esition (Name of matory or other place cematory	.		Oc. Location - City or Town, State Baltimore, MD				
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	99	9	Name and Address	s of Facility Ha	rdesty F	uneral Home, P.A. ille, MD 20765				
ba / bu, ificate be executed Examiner Be physician and Be the buriat-transit	edical Examiner	s ock or heart failtyfe. List only of Immutate Jause (Photography of Immutate a or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	quence of):	shot wo	inal		Interval Between Onset and Death				
death cert a attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year				
N 8 8 8	b	Part II. Other significant conditions co.	ntributing to death but not re	sulting in the u	nderlying cause give	en in Part I.		acco use contribute to the cause of death?				
The law rate has b page 2 s	Completed							prior to completion of cause of death? ☐ No 1 2 Yes 2 ☐ No				
UNISION OF VITA To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Yeer) 1	28b. Time of Injury 1844 home, farm, strify)	P 28c. Injury Work	er: 4 🗆 Nursing H	28f. Location (Stre City or Town,	nce Mother (Specify) At Scene				
e Hospita 24 hours e Funerel letely fille	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deatl	n occurred at the tim	ie, date and place pinion, death occur	and due to the cau	use(s) and manner as stated.				
To th Withir To th	Me	29b. Signature and title of certifier Zafuit		<i>l</i> =	29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 29, 2004							
A B		30. Name and address of person who co	4 AZI	11	ll Penn St	treet, Ba	altimore,	Maryland 21201				
Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 2	2004 32. Registrar's Sign	nature /	from.							

			1 - For State Registrar	State of M	Maryland / Depa Cer	artment of H			giene Reg. No. 200	4 02562			
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death			
	Physicia		Bertha	н.		Bieder	nann	Januar		4 12:00 a M			
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or			4c. County of I				
	LAGIIII		1686 Anne Court			Annapol	lis		Anne A	runde1			
	Funeral		Social Security Number 6. Sex		ige (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H		th 9.	Birthplace (State or Foreign Country)			
	Director		123 - 09 - 1790	M 25XF	88 Yrs.	Months Days	Hours Mi	Feb. 4,	1915 N	ew York			
	р ,		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo					10d Inside Ohulinia			
	shov	7	MD Anne Aru	ndo1						10d. Inside City Limits 1 √2 Yes 2 □ No			
	Ba-1	ecto	10e. Street and Number	nueı	Annapol			1	10g. Citizen of What Country?				
	with	ă	1686 Anne Court			10f. Zip Code	.O.1			it Country?			
	eath	by Funeral Director		12. Was Deceden	t Ever in U.S. 13 1	Vas Decedent of Hi		(Specify Yes or No.	USA 14 Bace -	American Indian.			
10	ter d	Fun	1 Never Married 2 Married	Armed Forces	97	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Pu	Black, \	White, etc.				
8	urs a	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates	"	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White			
Ö	within 72 hours after death with the Maryland ene. than "netural", or tlems 23a or 28a-f show the Mudical Exema for must be motified a	Completed	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation	netina	16b. Kind of Busin	ess/Industry			
2	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4o	life.	DO NOT use retired)	Orking					
7	ed wi	Con	12		Home	maker			Own Ho	me			
pu	d oth	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,	Maiden Sumame)				
₹	Men Men arke	ဥ	Christopher Schwe				Anna I						
Maryland 21215-0036	2 sh and is m	1	19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Street a	and Number or i	Rural Route Numbe	er, City or Town, Sta	te, Zip Code)			
e)	1 and 1ealth 3m 27 sm 27 ther t		Carol Melchner (D 20a. Method of Disposition	aughter)	1686 20b. Place of Dispo		ırt, Anr	na olis, I	MD 21401 20c. Location - City	v or Town State			
و	in ite		1 ⊠Burial 2 ☐ Cremation 3 ☐R	emoval from State	e cemetery, crer	natory`or other plac							
Baltimore,	permit. Pages 1 and 2 should be itied within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-1 show appringury or other traumatic event, the Mudical Examination in the multiple at once.		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyner S rvice Ligense			Heaven (31/2004 1	Mt. Pleas	ant, NY			
Ba	permi Depar Impo any ir		Valu A	Clarket		Hardesty 12 Ridge	Funera 1y Aver	al Home, l nue, Annaj	P.A. polis, MD	21401			
	5		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause ne cause on each	ed the death. Do not ent line.					Approximate Interval Between			
,	Physician		Immediate Cause (Final disease or condition	Conge	STIVE HE	art Fa	ilure			Onset and Death			
	/Medical Examiner		resulting in death)		s a consequence of):					0.01.0			
	LAMITHUE	_	Sequentially list conditions,	Aor	tic Ster	nosis				5yrs			
	be tis	Examlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):								
	and and al-trar	xan	that initiated events resulting in death) Last		s a consequence of):								
8760,	death certificate be executed e attending physician and of for use as the burial-transit	a			,								
687	ficate phys s the	adlc	0				-						
Box (eath certific attending p	J/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom					23d. Date of	delivery			
m	death e atte d for	icla	in the past 12 months? 1 ☐ Yes 2 No	4 Pregnant		Ectopic pregnancy Other (specify)			Month	Day Year			
0	y th	Physiclan/Medicai	9 □ Unknown	9□ Unknown									
ď.		ру Р	Part II. Other significant conditions con	tributing to death	but not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?			
ğ	law requires as been sign 2 should be	ed	Hypentension	Dem	entia			1 □ Y	es 2 X No 3	Probably 4 Unknown			
900	e law re has be je 2 shi	Completed						24a. Was autop		e autopsy findings available to completion of cause of			
Ě	o - &	mo.						perfor	rmed? deat	h?			
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of D	eath (Check only or	ne)				
<u></u>	Physician: this certific ral director,	2	1 ☐ Yes 2 No	lospital: 1 🗌 Inpat			4 🗀 Nursing	Home 5 Resid	lence 6 Other (Specify)			
П	ding Pl h. After tl funera		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time of lay Year) Injury	28c. Injury Work	at c?	28d. Describe h	now injury occurred				
sio	Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No						
Division of Vital Records,	al or Attendation after deatlet Director:	Certification;	4 Homicide determined	28e. Place of li building, e	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office		28f. Location (S City or Tow	Street and Number o m, State)	r Rural Route Number,			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one) Certifying Physical Examination	sicien: To the bes ner: On the basis and manner s	at of my knowledge, death of examination and/or invistated.	n occurred at the time vestigation, in my op	e, date and pla pinion, death oc	ce, and due to the c curred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)			
	ro th Mithin To th	Me	29b. Signature and title of certifier			29c. License	number	-	29d. Date signed (M	onth, Day, Year)			
	,		Fisa m.	110	10	D36	526		1/30/0	4			
	1		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type,		3310		10010				
_	9		LISA MURRAY	mo	2002 m	redical	Park	way E	070	Annapolis			
	Sta Registr		31. Date filed (Maril Dy, Med) 20	32 Aegis	trar's Signature	all!		,		٧			

			i lease i	State of Maryland	/ Department of Health and	Mental Hygier	le o o o i	
		•	For State Registrar	otato or marytama	Certificate of Death	Reg. N	_ / H H !! H / 5 f	63
Ø P	Physicia		1. Decedent's Name (First, Middle, Last)	11 Due	4.5		3. Time of Deal	
1	/Medic	al	4a. Facility Nama (If not institution, give s	M. Byer	4b. City, Town, or Location of De	JAN 4	29 04 12:10	P
	Examin	er	44 11' 1 14	NOV NUTSIA	1) 4		NH	
	uneral rector		5. Social Security Number 6. Sex 240 - 46 - 2617	M 2F0F 7. Age (In yrs. las		n. (Month, Day, Yea	9. Birthplace (State or For Country)	reign
land	MO		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Location		10d. Inside City Lir	mits
deeth with the Maryland	28e-f ah	Funeral Director	10e. Street and Number	H	B A / / W	10g. (1 Yes 2 Ditizen of What Country?]No
ath with	23a ol	rai Di		TER 51	2120	7	U.SH	
.0036 hours after dee	item 27 is marked other than "natural", or items 23s or 28e-f ahow other traumatic event, Ina Medical Examinal must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 ☐ Yes 2 ☐ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	_
21215-0036 Id within 72 hours af giene.	natura dical E	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	rorking 16b.	Kind of Business/Industry	
within ene.	than na Me	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Domos (-tie.	4	tome make	
Ind 2 be filed tal Hygi	other vent, I	Be Co	17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, Maid	en Sumame)	
Maryland d2 should be file the and Mental Hy	sarked	Tof	BASCOMBE	Dougla	SCAP	40/1A	5049195	
Mar nd 2 sh lith and	27 Is m r traum		19a, Informant's Name/Pelationship (Typ	1 SON	19b. Mailing Address (Street and Number or a	Rural Route Number, City BAGO	v or To State, Zip Code) No 2,207	1
ore, es 1 an of Heal	or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	cem	e of Disposition (Name of elery, crematory or other place)		Location - City or Town, State	
Baltimore Sermit. Pages 1 a Department of He	걸호		* 4 □ Donation ★□ Other (Specify)	1116	22. Name and Address of Ficility	2.04	14 Ry 1920	.
Balti permit. Departm	any in		21. Signature of Funeral Pervice License	Youll &	4600 LBE	204 1501.	BAR MAN	202
	14		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death.	Do not enter the mode of dying, such as card	ac of respiratory arrest,	Approximate Interval Between Onset and Death	n
4	sician edical		Immediate Cause (Final disease or condition resulting in death)	Cene	& Stay Demen	tion	andream	2
17/2	miner			Due to (or as a consequer	nce of):			
D D	=	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nce of):			
60, be execute	and al-trans	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequer	nce of):			-
9	attending physicien and for use as the burial-transit	cal						
K 68	ling ph e as th	Medi	IF FEMALE:					
ecords, P.O. Box 68 law requires that the death certifica	the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnance 1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year	
S, P.	signed by d be detac	by Ph	Part II. Other significant conditions con	-	ng in the underlying cause given in Part I.	1	o use contribute to the cause of death	
of Vital Records, Physicien: The law requires t	been sig	ted	Mule	Mucja		-	2 No 3 Probably 4 Unknown	
Rec 18 law	has Je 2	Completed	1755	Mueja		24a. Was an autopsy performed?		lable a of
ital R	ate	e e	25. Was case referred to medical		26. Place of D	eath (Check only one)	√o 1 ☐ Yes 2 ☐ No	
of Vita	his cer Il direc	To B		ospital: 1 ☐ Inpatient 2 ☐ EF		Home 5 Residence		
dang P	After t funera	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	Bb. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Division for Attending after death.	Diractor: I in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
Hospital 24 hours	To the Funerel Diractor: After this certific completely filled in by the funeral director.	edical Co	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred at the time, date and pla n and/or investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)	
To the	To the	Me	29b. Signature and title of certifier	(4)	29c. License number		Date signed (Month, Day, Year)	
			1	(m)	1)27569	7 2	12/04	
	2	- 6	30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type, Print)	Freene	Tree Nel	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur				
1 2 1	Registr	ar	* EB	0 2 2004 Marc	che the desire			

			For Stete Registrar	State of Maryland	d / Depa <i>Cer</i>	irtment of He tificate of E	ealth and M Death	ental Hygie	ene 2001	02564
Ė			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia	_	LESLIE	н.	BRAI	SHAW		January	24, 2004	8:50 P M
	/Medic Examin	_	4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Death		4c. County of Deat	h
	Examin		Calvert Memorial F	Mospital		Prince	Frederic	ck	Calv	ert
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birt	hplace (State or Foreign untry)
	Director		220-32 - 2384 ¹ ₽	M 2□F 70	Yrs.	Months Days		July 5, 1		land
	ט		Usual Residence of Decedent							
	ylan how		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mai	ţ	Maryland Calve:	rt		North E	Beach			1√2 Yes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?
	h wit		4001 7th Street				20714		USA	
	deat	Funeral		Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spanic Mexican, Puedo	ecify Yes or No-	14. Race - Ame Black, Whit	
٥	after or Ite		1 ☐ Never Married 2 ☐ Married	157Ves 2□No		I □ Yes 2 ☑ No	Specify:		Specify: Wh	_
3	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23a or 28e-f show Ite Madical Examirar must be notified at	þ	3 ☐ Widowed 4 ★ Divorced	If Yes, Give Korean Year or Dates Conflic	t L	10 163 2 M	Specify.		Specify. WI	
5-0036	72 hc	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occupa kind of work done of	ition Juring most of worki	ng 16	b. Kind of Business/	Industry
Z	within 72 ene. than "na	ģ	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. I	kind of work done d OO NOT use retired)	,			
7	filed wi Hygien ther th	6	8			co-owner			eafood car	ry out
2	uld be filed Aental Hyg rked other tic event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		,	
Maryland	should bind Ment	ဥ	Preston M. Bradsh	aw			Arinthia	Viola Ev	<i>r</i> ans	
a	2 sho and Is me		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street a	nd Number or Rura	al Route Number, (City or Town, State, 2	Zip Code)
	is 1 and 2 should of Health and Men item 27 is marke other traumatic		Theresa R. St. Jo	hn (Daughter)	.4017	th St P.	O. Box 147	5 - North E	each, Maryl	and 20714
Se	of He		20a. Method of Disposition	C6	ace of Dispo emetery, crei	sition (Name of natory or other place		Date 20	c. Location - City or	Town, State
Ĕ	Page nent nt: II		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	Sunn	yridge	Memorial Pa	rk Jan.3	0, 2004 Cr	isfield,	Maryland
altimore,	permit. Pages Department of I Importent: If its eny injury or o pnce.		21. Signature of Funeral Service License	2 in deline De	· # 2	Name and Addres	s of Facility	neral Hom	10	
ä	F F F G		Mary Beth Bra	shaw-Pruitt					eld ,MD 2	1817
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death	. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arres	t,	Approximate Interval Between
	resonate to a		Immediate Cause (Final	e cause of each line.						Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or a la consegu	ence of):					
	Examiner	1		Danie as -						
		ia la	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. Due to (or as a consequ	ience of):					
	ted nsit	를	Cause (Disease or injury that initiated events	1 1110 0	Panci					
•	xecu and al-tra	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequ	ience of):					
9	ficate be executed physician and is the burial-transit	al		3						
38760,		edical							,	
ŏ	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as		IF FEMALE:	3c. If yes, outcome of pregna	ncy				23d. Date of del	livery
B	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
o.	at the de by the a tached i	ysic	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown						
٥.	that t ed by deta	문	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Ę,	ires that signed to d be deta	1 by						1 XYes	2 □ No 3 □ Pr	obably 4 Unknown
0	w require been si should t	etec						242 145 2 2 2	0.45 14/200 00	uta-su finalisas susilabla
Records,	e law has t je 2 s	ğ						24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of
	ding Physician: The I h. After this certificate ha funeral director, page	Completed							No 1 ☐ Yes	2 □ No
Division of Vital	sian: ertific ector,	Be	25. Was case referred to medical examiner?					h (Check only one,)	
Ž	hysia his c	ဥ	1 ☐ Yes 2 ② No		ER/Outpatie		4 U Nursing Ho		ce 6 ☐ Other (Spe	city)
0	ng P fter t mera	ü	27. Manner of Death f	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work		28d. Describe how	injury occurred	
ö	endi sath. or: A he fu	ati	2 Accident investigation				Yes 2 □ No			
<u>≅</u>	for Attendation of the formal	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ri State)	ura i Route Number,
	italo rsaft alDi	O		<u> </u>			!			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, a	edical	29a. Certifier Certifying Phys	sicien: To the best of my kno- ner: On the basis of examinat	wledge, deat tion and/or in	h occurred at the tim vestigation, in my or	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	s stated. e to the cause(s)
	the k	led	one)	and manner stated.						
	Vitt To COT	Σ	29b. Signature and title of deditter			29c. License	o number	_ 290	d. Date signed (Mont	Jay, real)
	/		11/			D.	2/940		1/25/2	74
	15		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print) Dr. G	allitan	1.1	MA	20678
_	-		110 Hoppit	al Roy Duch	2 300	Minc	e prod	erolle	1100	20010
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	40 .		-		
	Regist	13	teen a 9 7884	Esa V	A Stanton	A 85 B				

		1	For State Registrar	State of Maryland / Department of Health and Mental Hygiene 2004 0256 Certificate of Death Reg. No.									
	Physicia	an	Decedent's Name (First, Middle, Last)	_ ¬	lae Be	Lcher		2. Date of Death Month January	Day 27, 20	Year 004	3. Time of Death 8:20 P M		
	/Medic Examin ———— Funeral	er	4a. Facility Name (If not institution, give : 2945 Cornwall Roa 5. Social Security Number 6. Sep	ad 7. Ag	ne (In yrs. last birthday)			8. Date of Birth		altir	place (State or Foreign		
	Director		Usual Residence of Decedent] M 2853xF 6	66 Yrs.		burs Min.	April 15	,1937	Mar	yland		
	ne Marylan 8a-f show offitied at	Director		Ltimore	10c. City, Town or Lo	10f. Zip Code	Du	ındalk	g. Citizen of W		10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than *natural*, or items 23e or 28e-f show avent, the Modical Examiner must be notified at	Funeral Dire	10e. Street and Number 2945 Cornwall I 11. Marital Status 1 □ Never Married 2 □ Married	Road 12. Was Decedent Armed Forces 1 □ Yes 2 □	,	·	21222 nic Origin? (Spiexican, Puerto	ecify Yes or No-	14. Race		can Indian,		
15-0036	n 72 hours af "natural", or adical Exem	ρ	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu (Specify only highest grad	If Yes, Give Year or Dates: cation	16a. Dece	1 ☐ Yes 2 IXNo Sp ident's Usual Occupation a kind of work done during DO NOT use retired)	g most of work	ing	Specify 6b. Kind of Bu	W.	hite		
nd 212	be filed within all Hygiene.	Be Completed	Elementary/Secondary (0-12) 12 Years 17. Father's Name (First, Middle, Last)	College (1-4or	5+)	ef		e (First, Middle, M.	Food I		try		
The Figure 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, or Rural Rout											21222		
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		Oak Lawn	cemetery.	1/31/20	004	_	more	, Maryland		
■ Balt	permit. Page Department of Important: If any injury or		21. Signature of Euneral Service Licens 23a. Part1. Enter the disease, or comp	lications that cause	the death. Do not en	2 Name and Address of Duda-Ruck F 7922 Wise A ter the mode of dying, su	ve. Di	ındalk, M	arylan		nc. 1222 Approximate Interval Between		
8760,	The law requires that the death certificate be executed with the law requires that the death certificate be executed with the law requirement and with the law requirement that the law requirement is a law requirement.	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or an	s a consequence of): a consequence of): a consequence of):	OBES	ES7				Onset and Death		
.O. Box 6	that the death certific led by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat Mo	e of deliv	rery Day Year		
Q	w requires that the peak by th	by	Part II. Other significant conditions co	ntributing to death	but not resulting in the		Part I.	23e. Did toba	_/		the cause of death? bably 4 □Unknown		
of Vital Records,		e Completed	Ch K ON (25. Was case referred to medical	CELL	DR ILA YUTIS	TION	Place of Deal	24a. Was an autopsy perform 1 Yes 2'	ed?	orior to co death?	opsy findings available ompletion of cause of		
n of Vit	ding Physician: h. After this certifica	To B	examiner?	Hospital: 1 Inpat	ury 28b. Time	ent 3 DOA Other: 4		ome 5 Resider 28d. Describe how	nce 6 Oth		fy)		
Division	deati ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	njury - At home, farm, s atc. (Specify)		2 No	281. Location (Str. City or Town,		er or Rur	al Route Number,		
	To the Hospitel or A within 24 hours after To the Funerel Dirac completely filled in by	Medical C	(Check only 2 Medical Examone)		of examination and/or i	ath occurred at the time, dinvestigation, in my opinio	on, death occur	rred at the time, da	te and place,	and due t	to the cause(s)		
	To To	2	29b. Signature and title of certifier 30. Name and address bl person who of	J W	death (Item 23a) (Type		72 8		d. Date signed	0	64		
	St.	ate	0			3	nore, Ma	aryland	21239	٧			
	Regist		FEB 0	2 2004	ch Raven Bl								

Registrar DHMH 17 Rev 1/2001

.1N	BRICE	1	State of Maryland / Department of Health and M State of Maryland / Department of Health and M State of Maryland / Department of Health and M Registrar		
	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month JAN . 10	Day Year 3. Time of Death 11:25A M
	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	UAIV. IC	4c. County of Death
	Examin	er	53 NORTH CATHERINE STREET BALTIMORE CITY		NA
	Funeral Director		5. Social Security Number 212-74-4198 6. Sex 192 M 2 F 7. Age (In yrs. last birthday) 45 Yrs. 11 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept 13, 19	ar) 5 8 Hary and Grand G
,	and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location		10d. Inside City Limits
	Maryla f sho	tor	Md. N/A Baltimore		1 X Yes 2 □ No
	r 28a	irec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	23a c	ralD	J3 h. Catherine St. 21223	ait. Van an Na	14. Race - American Indian,
96	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avent, the Medical Exam are must be notified at	by Funeral Director	11. Maritat Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Very Never Married 2 Married 1 Pres 2 No If Yes, specify: 1 Pres 2 No If Yes 2 No	Rican, etc.)	Black, White, etc. Specify: Black
9	2 hour		16 Decedent's Education 16a Decedent's Usual Occupation	16b	. Kind of Business/Industry
Maryland 21215-0036	within 7 ane. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Castodia Give kind of work done during most of working life. DO NOT use retired) Castodia Give kind of work done during most of working life. DO NOT use retired		Education
d 2	Hygie other	0	7 0	(First, Middle, Main	
/lan	2 should be filed within and Mental Hygiene. Is marked other than aumatic avent, Ira M	To B	Andrew Brice her	Smith	<u> </u>
Jan	2 shound Min and Min a		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura 19c. Mailing Address (Street and Number or Rura 5371. Catherine	I Route Number, Ci	ity or Town, State, Zip Code)
	1 and 2 Health tem 27 other tr			Date 200	: Location - City or Town, State
ē	Pages nent of I int: If It		1 Burial 2 Officemation 3 Hemoval from State OVE In Mount Cram. Jan 2	2, 2004	Ball. Ad.
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licensee 22. Name an Address of Facility (1) 1701 Mc Cullah	st. Bals	eral Service P.A. w. ud. 21217
			23a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a. Arteriosclerotic cardiovascular disease		Oriset and Double
7	/Medical Examiner		resulting in death) Due to (or as a consequence of):		
	, Tel	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·	
	scuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
8760,	icate be executed physician and s the burial-transit	ai Ex	resulting in death) Last Due to (or as a consequence of):		
687	ficate physics the	edlcai	d		
.O. Box	The law requires that the death certificate has been signed by the attending forge 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
4	res that the de igned by the a be detached i		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
rds	w requires been sign should be	ed by		1 🗆 Yəs	2 No 3 Probably 4 Unknown
Records,	ne law requ has been ge 2 shoul	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al R				1/10/Yes 2	
Vital		o Be	examiner?	n <i>(Clieck only one)</i> me 5 ☐ Residenc	e DOOther (Specify) AT SCENE
on of	ding After fune	H-	X -	28d. Describe how	
Division	- O ()	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or At within 24 hours after d Vithin 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one). 29a Certifier (Check only one). 29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the caus red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and little of certifier 29c. License number	29d	Date signed (Month, Dey, Year)
	F S F O		O.C.M.E		JAN. 11, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Afon with M111 Penn Street, Baltimore,	Maryland	1 21201
	S	ate	31. Date filed (Month, Day, Year) / 32. Registrar's Signature		
	Regis		FEB - 2 2004 Seneral B sporks		

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month PM Physician JANUARY 31 4004 MILLIAN ASON. SART /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAL ImoRE If Under 1 Year If Under 24 Hrs. 10 12261 Koun W000 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Months 1 M 2 F 74 Yrs. AND - 33-074r Director 3119 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State 28a-f ahow in than "natural", or items 23a or 28a-f ahov the Medical Exprimer is ust be notified at 1 ☐ Yes 2 No Directo BOIL MARYLAND nuinoni, 110082 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number DOOW 15000 31093 Completed by Funeral 13991 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 250 Married 1 ☐ Yes 25 No Specify: WHIT Maryland 21215-0036 1 ☐ Yes 25 No If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed withing the filed withing the file and Mental Hygiene. Int: If item 27 is marked other than Honzmake 12485 1B5. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SUBELHARD William ဂ 21093 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13361 KOUN 8 MOCHUT 01270L other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore, Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: if any njury or once. ö 4 □ Donation 5 □ Other (Specify) 2004 22. Name and Address of Eacility
PARE FOL ALLEY
LANGE ASSA TRAL+CREP 21. Sonature | Funeral Service Licens YORK Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner sola Sequentially list conditions, Due to (or as a consequence of): Examiner n any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be execu P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day ō 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ T⊠ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an has e 2 autopsy performed? page Yes 2□ No certificate 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home Standard 6 Other (Specify) Certification: To 1 Yes - No this 28a. Date of fnjury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation **†** ≤Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Well 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAI 31. Date filed (Month, Day, Year) 32. Registrar' signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02568 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** North W. Brady January 16, 2004 4:15 PM /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Genesis Heritage Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 11☑M 2□F 265-09-5391 Yrs Director July 14, 1905 <u>Pennsylvania</u> Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits l show permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Health and Mential Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6707 Averill Road T-C21237 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces?
1 (2)Yes 2 No 124-1179, Give 123 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 24-27 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 🖾 Divorced 133-36 Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) security guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John W. Brady Laura Esther McManus ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lynn Dabrowski/daughter 12 Flagship Road Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease or or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ettending physician end I for use as the burial-transit requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☑ No i or Attending Physician: efter deeth. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 Z No 2 ER/Outpatient 3□ DOA Certification: To completely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 1 v Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32 Registrar's Signature FEB 0 2 2004

DHMH 16 Rev 6/95

Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26, 2004 JANUARY **Physician** BADIEE NOSRATOLLAH 12:47 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 33 HIDDEN CREEK COURT OWINGS MILLS BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | SEP 1 23,1917 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** IRAN 215-59-4461 86 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No OWINGS MILLS Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 HIDDEN CREEK COURT 21117 IRAN death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) WHOLESALE OWNER Pages 1 and 2 should be filed vitment of Health and Mental Hygie tant; if Item 27 is marked other iury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BADIEE TAJSULTAN KHOZEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 SHADED GLEN COURT - OWINGS MILLS, MD 21117 NADIA ASSADI / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State DRUID RIDGE CEMETERY 1/30/2004 PIKESVILLE, MD * 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. M 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter this disk ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac or respiratory arrest, but the mode of dying, such as cardiac or respiratory arrest, but the mode of dying, such as cardiac or respiratory arrest, but the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ending physician use as the buria Physician/Medical IF FEMALE 23c. Il yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been sig., page 2 should b 1 🗌 Yes 2 DENO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1 Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D48261 MD PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd #325 Lutherville MD 2108 10753 +olugia 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Rober 04-00		tt	Baysmore, Sr. Please	Type or Print	in Bla	ck Inc	lelible lnk.	Ensure	All Copie	s Are	Legible).
crn			1 - For State Registrar	State of Mar	yland /		rtment of F tificate of		Mental H	ygiene Reg. No	200	02570
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las ROBERT E . E Las Facility Name (If not institution, give	BAYSMORE	SR.		4b. City, Town, o	r Location of De	2. Date of D Month Janua	ry 28	y Ye 3 , 2004 County of D	4 11:54 A M
	Funeral Director		301 McMechen Stre 5. Social Security Number 6. Security Number 213 32 4478		ent 21 In yrs. last t		If Under 1 Year Months Days	Baltimon If Under 24 Hi Hours Min	s. 8. Date of B	irth Day, Year)	N/2 9.	A Birthplece (State or Foreign Country) D •
	D	ctor	Usuel Residence of Decedent 10a. State		0c. City, To		ation IMORE	1 1	AUG. C	,,,,,		10d. Inside City Limits 1√√ Yes 2 □ No
	ath with the	ral Director	10e. Street and Number 301 MC MECHEN				J	1217		U	S.A.	
9800	72 hours after death with the Maryland naturel', or tems 23s or 28s-f ehow Jisal Exactivat for collified at	d by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.	If	/as Decedent of H Yes, specify Cubi ☐ Yes 2 No	dispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - American Indian, Black, White, etc. Specify: BLACK	
altimore, Maryland 21215-0036	within ane. then	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12TH			(Give k life. D	ent's Usual Occup und of work done O NOT use retired	during most of w	rorking		(ind of Busine	ess/Industry
ryland	should be filed nd Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) JOSEPH BAYSMO 19a. Informant's Name/Relationship (7)	-	10	9h Mailin	Address (Street	ZORAH	PUNDY			a Zin Code)
re, Ma	ss 1 and 2 st of Health and item 27 is r		ROBERT BAYSMORE 20a. Method of Disposition		N) 1	614	INGRAM ition (Name of atory or other place	ROAD		RE,	MD.	21239 or Town, State
Baltimo	permit. Pages Department of Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specify 21. Stonature of Funeral Service Licen			LAWI		ERY FE				ORE,MD.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	nsine	o not ente	r the mode of dyin	ng, such as cardi		arrest,	·	Approximate Interval Between Onset and Death
760,	te be executed ysician and ne burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
	he death certificate be ex the attending physician : thed for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal dea		Ectopic pregnancy Other (specify)	/			23d. Date of Month	delivery Day Year
rds, P.	quires that the de in signed by the uid be detached	þ	Part II. Other significant conditions of	ontributing to death but	not resulting	in the un	derlying cause giv	en in Part I.		tobacco (e to the cause of death?
al Reco	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	Completed								opsy formed?	prior	
Vita	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 □XYes 2 □ No	Hospital: 1 ☐ Inpatient	2 🗆 ER/0	Outpatient	3□ DOA Oth		eath (Check only Home 5 ☐ Res		6 ⊠Other (S	ipecify) at scene
vision o	Attending death. ctor: After y the fune	Certification: 1	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined			farm, stre			28d. Describe	how inju	ry occurred	Rural Route Number,
Ö	e Hospital or / 24 hours after e Funerel Dire	edicai Cert	29a. Certifier 1 Certifying Ph	ysician: To the best of inner: On the basis of e	my knowled xamination a	ge, death	occurred at the tir		ce, and due to the	e cause(s) and manner	
_	To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner state	d.		29c. Licens	e number		29d. Da	te signed (Me	onth, Dey, Year)
	6		30. Name and address of person who	h 42 completed cause of dea	th (Item 23a	1) (Type, F		C.M.E.	1	Ja	nuary	29, 2004
			ZABILLEAH +	32. Registra	4/ /	111 I	Penn Stre	et, Bal	timore,	Mary	land 2	21201
	Sta Registr		FER A	2 2004	orginature	K	Soule	,				

			State Registrar	-	urtment of Health and I	F	Reg. No.	02571
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) OAUID ROLAN.	D CARTER		2. Date of Dea Month Januar	Day Year	
	Examin		4a. Facility Name (If not institution, give street an	d number)	4b. City, Town, or Location of Death Baits NUCC	1 5	4c. County of Dea	ath 2
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	9. Bi	orthplace (State or Foreign Country)
	laryland show	or.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			,	10d. Inside City Limits
	vith the N or 28a-f	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	
(0	be filed within 72 hours after death with the Maryland nat Hygiene. Ind Hygiene. Ind chief than "natural", or items 23a or 28a-f show adother than "natural", or items 23a or 28a-f show swent, the Medical Examinar must be nutilised at	Funerai	Never Married 2 Married 1	Decedent Ever in U.S. 13. Ved Forces?	Was Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	erican Indian,
21215-0036	72 hours a "natural", c	eted by	3 Widowed 4 Divorced Year 15. Decedent's Education (Specify only highest grade comple	or Dates: 16a. Deced (Give	Yes 2 No Specify: lent's Usual Occupation kind of work done during most of work	king	Specify:	acle s/Industry
d 2121	filed within Hygiene. sther than "	e Completed	Elementary/Secondary (0-12) Colle 17. Father's Name (First, Middle, Last)	ige (1-4or5+)	18. Mother's Nar		SHO GUN Maiden Surname)	RESMUMENT
Maryland	d 2 should be th and Mental 7 is marked of traumatic sve	To B	184 CARTER, ST. 19a. Info mant's Name/Relationship (Type, Print)	19b Maille	g Address (Street and Number or Ru	LEE Number	BATK GT	Zin Codo)
	1 and 2 Health a em 27 is ther tra			20b. Place of Dispos	Street	Date Paris	ti reare M 20c. Location - City o	Av lovo
Baltimore,	nit. Pa artmen ortant: injury injury		1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	from State Greenalous	natory or other place) If Comether 1 Name and Address of Ficility (2) Zer Done 1 Construction	38-04 4A-14A	BALTINER - HAMIT	Marylans
ä	permi Depa Impo any ii		23a. Part 1. Enjer the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not enter	MANWE, ILL 2	14/		Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis e to (or as a consequence of):				Onset and Death Unknown
)	Examiner	ler	Sequentially list conditions b.	HIV-AIDS				unknown
30,	death certificate be executed e attending physician and d for use as the burial-transit	I Examin	that initiated events	e to (or as a consequence of):				
(68760,	artificate b ing physic s as the b	Medical	d					
О. Вох		Physician/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of de Month	olivery Day Year
s, P	es tha	ρ	Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
of Vital Record		Completed				24a. Was a autops perfor 1X Yes	an 24b. Were a prior to death? 2 \(\begin{array}{ccccc} 2 \(\begin{array}{ccccc} 1 \(\beta\) Ye.	utopsy findings available completion of cause of
Vita	Physician: This certificatal director, p	To Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No Hospital:	1 Inpatient 2 ☐ ER/Outpatien	Othor	th (Check only or	ence 6 Other (Spe	ecity)
	Attending Physic death. sector: After this by the funeral di		27. Manner of Death 28a.	Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 \(\text{Yes} 2 \(\text{No} \)		ow injury occurred	July
Division	Di di	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Si City or Town	treet and Number or R n, State)	lural Route Number,
	한 다 가 들이	edical	(Check only 2 Medical Examiner: On	o the best of my knowledge, death the basis of examination and/or inv manner stated.	occurred at the time, date and place restigation, in my opinion, death occurred	rred at the time, d	late and place, and du	e to the cause(s)
	To the l within 2 To the l complet	Σ	29b. Signature and title of certifier	Sott	29c. License number AT 24 38946 -		January	_
	3		30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print) Union Memorial	Hospital ersity Pa	rkway	
	/		1 11.100 - 1001 - 11		Baltimore, M.	D 21218	3-2895	

_			1 - For State Registrar	State of Ma	aryland				lealth a Death	and M	ental Hy	/giene	200		2572
	Diversity		1. Decedent's Name (First, Middle, Last)								2. Date of D	eath Da	v Y		ime of Death
	Physici /Medio		Paul	Fra	nk			Car	ter	III	Januar	242		004 13	50 PM
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	of Death	,	40	. County of	Death	
			Sinai Rospitat	of Bala	timor.	e	Bal	tim	ORE	Cit	4				
	Funeral		5. Social Security Number 6. Sec	7. Ag M 2□F	e (In yrs. la:		If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9	Birthplace (S Country)	State or Foreign
	Director		212-58-4202	¥M ZUF	43	Yrs.					10	25	60	ΜĎ	
	put &		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation							10d Inc	ide City Limits
V	anyla sho	7													Yes 2XXXI
~	death with the Maryland ms 23s or 28e-f show	ect	MD Baltin	nore		Pikes									74.63
7	Nith t	눕	10e. Street and Number	-			10f. Zip					10g. Cit		at Country?	
(i)	s 23c	in a	12 Red Jonathar		- · · · · · ·	1.0			1208				U.S.		
(er de Item	Funeral Director	The manual dialog	12. Was Decedent Armed Forces?		. 13. 1	f Yes, spec	offy Cuba	ispanic Orig in, Mexican	, Puerto F	ofy Yes or Na Rican, etc.)	٥-		American Ind White, etc.	an,
36	rs aff	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√2√ If Yes, Give Year or Dates:	40		1 🗆 Yes	2 🔀 No	Specity:				Specify:	Blac	k
~/ 👇	172 hours after death with the Marylar *natural; or Items 23e or 28e-f show talcal Examinar must be notified at	ed	15. Decedent's Edu			16a. Deced	dent's Usua	al Occupi	ation			16b K	ind of Busi	ness/Industry	
7.5	in 72	Completed	(Specify only highest grade	e completed)		(Give	kind of wo	rk done d	durina most	of workir	g	Vil	la M	laria	
25	with	E	12th grade	College (1-4or 5	0+)		Cour	nse1	or			Tre	eatme	nt Ce	nter
40	Hygi other	BeC	17. Father's Name (First, Middle, Last)	ZYLD			0041	.002		r's Name	(First, Middle	, Maiden	Sumame)		
2 t	ld be ental ked c	To B	Paul F. Carter	Jr.					Mari	e 01	ieen				
© €	should nd Men marks marks	-	19a. Informant's Name/Relationship (Ty			19b. Mailir	ng Address					er, City o	or Town, St	ate, Zip Code)	
ଁ ର ≅	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, ILA N. 2006.		Deedri Rowlan-C	arter-W	life	12 F	Red i	Iona	than	Ct.	Pike	esvi	116.	МД	21208
<u>5</u> 5	F Hez		20a. Method of Disposition	Jar Jar	20b. Pla	ce ol Dispo	sition (Nan	ne of			ate	T		ity or Town, St	
OF OF	Page ent o ht: If		XIXBurial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	lemoval Irom State		g Men	-		1	2/5	/04	Dan	da 11	stown	Μđ
altimore,	ortan injui		21. Signature of Funeral Service I Cens	3e ,	11.111				is officially		0-1	Ran	Idali	SCOWII	, HG
ñ	Depa Impo any is		1 Hobino	DESE	73						Balt	imor	e Md	2121	5
			23a. Part1. Enter the disease, or compli	cations that caused	the death.									Appro	ximate
			shock, or heart failure. List only or Immediate Cause (Final	0. 1		1	. /							Onset	al Between and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as		tern	ati	on						30	lays
11	Examiner		[Trehei			P. 10	103 8	minlo	0 0	recid	0 107	j	40	2000
AV.		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as		-	ORU	v enc s	Car cure	-1 6	CCIPI	enc	_	1 01	lety's
C	uted d ansit	Examine	Cause (Disease or injury												
ć	be executed ician and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):									
760,	eath certificate be exattending physician for use as the buria	cal													
	tificat ng phy as th	=									+	-			
X	ndin use	Z	IF FEMALE: 23b. Was decedent pregnant	3c. Il yes, outcome			-						23d. Date o	ol delivery	
m	death d for	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			Ectopic pr Other (sp						Month	Day	Year
0	that the death cer ed by the attendir detached for use	hys	9 Unknown	9□ Unknown											
υ. σ	res that igned b	Completed by Physician/Med	Part II. Other significant conditions con	tributing to death b	ut not result	ing in the ur	nderlying c	ause give	en in Part I.		23e. Did	tobacco L	use contribu	ute to the caus	e of death?
ž.	quire n sig uld bi	D D	hypertension	າ							1 🗆	Yes 2	□No 3[☐ Probably	4 DUnknown
္မ	w requires been si should!	lete	01								24a. Was		24b. We	re autopsy find	lings available
æ	he lav e has age 2	E										ormed?	dea	or to completion th?	
ta	ding Physician: The In. h. After this certificate ha funeral director, page	a	25. Was case referred to medical			-			26 Place	of Death	1 Yes		1 10	Yes 2 N)
5	/sicia s cert	To B	examiner?	lospital: 1 [Inpatie	ent 2∏EF	R/Outpatien	t 3[] DO	Othe			e 5 ☐ Resi		6 □Other	(Specify)	
9	g Phys er this eral dii	Ë	27. Manner of Death	28a. Date of Injui		8b. Time of		8c. Injury Work			8d. Describe				
<u>.</u>	nding l ath. r: After e funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	y 1 Gar)	Injury	М		r Yes 2∐N	40					
Division of Vital Records, P.O. Box 68	l or Attendi after death. Diractor: A i in by the fu	iţi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju-	ury - At hom	e, larm, stre	et, factory	, office		2	Bf. Location (City or To			or Rural Route	Number,
۵	s afte	Certification:	Tiomiciso	building, etc	o. (Specify)						City of 10	wii, Sialo	,		
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as to	cal	29a. Certifier 1 V Certifying Phys	sician: To the best of	of my knowl	edge, death	occurred	at the tim	e, date and	d place, a	nd due to the	cause(s)	and mann	er as stated.	una(n)
	the H in 24 the F	Medical	one)	and manner sta	ated.	androi iriv				00001119	- at the time,				
	To t To t	Σ	29b. Signature and title of certifier	1 n	20			_	number	00				Month, Day, Ye	*
			Markai	w, 11			K	、上、	5 - ($\mathcal{I}\mathcal{U}$	0	Jan	uary	128,8	2004
	11		30. Name and address of person who co	\wedge \cap	0 .	(Type, I	- 2 1		10		0	D	0	timo	
_	10		Mariya t. 1		nd, 1	nu	51	nai	HO	spit	tal	of	Bal	timo	re
	Sta Registr	100	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatui		r 1	00-00							

	4-00439 AP			State of Maryland / Der	partment of Health and	Mental Hygier	ne .	
D	AF	•	= State Unpend Item #23. Registrar	State of Maryland / Dep a,27,28a-f per me G828	entificate of Death	Reg. N	.2004	02573
	Physicia /Medic		1. Deesdon's Name (First, Middle, Las	51). G. Cole	man		2004 Year	3. Time of Death 5:38 a M
	Examin		4a. Fecility Name (If not institution, give 911 NORTH FULTON		4b. City, Town, or Location of Death BALTIMORE CITY	h ·	tc. County of Death	12
	Funeral Director		219-86-9294	ex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Dey, Yea	9. Birthp Coun	lace (State or Foreign try)
)	Maryland -f ahow	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town of	to Al Timora		11	0d. Inside City Limits 1 Yes 2 □ No
	th with the 23s or 28s	al Director	10e. Street and Number	eto- ST	10f. Zip Code 2/2/	7 10g. 0	Citizen of What Coun	A A
980	72 hours after death with the Maryland natural', or Items 23s or 28s-f show oldal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces 2 1	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	within ene. then	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) 16a. De (Gingleted) 16a. College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of work DO NOT use retired)	rking 16b	Kind of Business/Ind	oustry NG
Maryland 2	should be filed and Mental Hygid is marked other sumatic sysnt, II	To Be C	17 Father's Name (First, Middle, Last)	leman	18. Mother's Nan Gen	ne (First, Middle, Maid	en Sumame) (KSO)	n.
	1 and 2 sho Health and Iem 27 is mu		19a. Informant's Name/Relationship	Type, Print) 19b. Ma 1eman Mothe 9,	ailing Address (Street and Number or Rull)	ural Route Namber, City L. Bal	or Town, State, Zip	21217
Baltimore,	nit. Pages 1 and artment of Health ortant: If item 27 injury or other ti		20a. Method of Disposition 1 Denial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specific	Removal from State	sposition (Name of strematory or other place)	Date 20c. 3-04 N	Location - City or To	wn, State
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	will	4600 UBERTY	owell	uneral	Homa 2007
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only tmmediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not e one cause on each line. Narcotic and alcohol Due to (or as a consequence of):		c or respiratory arrest,		Approximate Interval Between Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b				
,092	ite be executed sysician and ne burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ry Day Year
rds, P.	quires that on signed b	by	Part It. Other significent conditions of	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to th 2 ☑ No 3 ☐ Prob	e cause of death? ably 4 Unknown
I Records,		Completed				24a. Was an autopsy performed?	prior to con death?	psy findings available inpletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	ath (Check only one)	****	1E 0000E
of	S S	: To	1X Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time	e of 28c. Injury at	lome 5 Residence 28d. Describe how in		AT SCENE
sion	Attending For death. Sector: After by the funer.	atlor	1 Natural 5 Pending 2 Accident investigation	round round	y Work? 1 ☐ Yes 2 🛣 No	unknown		
Division	of or Attence after death of Diractor:	Certification:	3 Suicide 6 Could not b 4 Homicide determined			28f. Location (Street City or Town, Sta Baltimore, Ma	1(e)911 N Fult	Route Number, con Avenue
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	ledical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medicat Exer	hysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place	, and due to the cause	(s) and manner as st	ated. the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	Goerbey MD	29c. License number CCME		Date signed (Month, L TUARY 16,2	•
			30. Name and address of person who Tasha Z Green	completed cause of death (Item 23a) (Type 111	oe, Print) 1 Penn Street, Bal:	timore, Mar	yland 212	01
	Sta	te	31. Date filed (Month Day, Year) 20	32. Registrar's Signature	long			

		A21	1 - For State Registrar	State of	Marylan		artment of H rtificate of L		and M		jiene leg. No.	004	02575
	Physici		Decedent's Name (First, Middle, La: JOSEPH LAWRENCE		SKY					2. Date of Dea Month JANUAR		2004	3. Time of Death 12:45 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and numb	oer)		4b. City, Town, or	Location o	of Death			ounty of Death	
			8629 WILLOW OAK	ROAD			RIDGEI	EIGH			В	ALTIMO	RE
	Funeral Director		5. Social Security Number 6. S 216-01-5493	ex 7.	. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under: Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day 10/13/	, Yeer)	9. Birth Cou MAR	place (State or Foreign intry) YLAND
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Maryli f sho	jo	MD BALTIM	ORE		RIDGE	T.ETGH						1 ☐ Yes 2 ☑ No
	r 28a	rec	10e, Street and Number				10f. Zip Code				l0g. Citize	n of What Cou	intry?
	th with	al D	8629 WILLOW OAK	ROAD			21234	ł			US.	Α	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show ship injury or other traumatic event, it a Mudical Examinat must be retilined at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceded Armed Force 1 Types 2 If Yes, Give Year or Date	es? □ No		Was Decedent of Hi f Yes, specify Cuba 1 Yes 2 No	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		Race - Ameri Black, White	
8	2 hou	ed	15. Decedent's Ed	lucation	55. 00 00 1 1	16a. Deced	dent's Usual Occupa	ition			16b. Kind	of Business/Ir	
21215-0036	hin 72	ple	(Specify only highest gra	de completed) College (1-4	or 5+)	(Give life. l	kind of work done a DO NOT use retired,	luring most)	t of workin	ng			
	filed wit Hygiene other the	Con	10TH GRADE		,	QUAL	ITY CONTRO	OL				GM	
Maryland	tial Hydrau of oth	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden Su	mame)	
Z	should be nd Mental marked c	٦	ANTON CHLUMSKY	Euro Orion		105 11-75		AGNE					
Z	d 2 sl th and th sr traur		19a. Informant's Name/Relationship (AGNES SINNOTT	DAUGF	TFP		ng Address (Street a CALIFORN			BALTIMO			
	tem 27		20a. Method of Disposition	Driodi	20b. P	lace of Dispo	sition (Name of			ate		tion - City or T	
9	Pages nent of ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donatjón 5 ☐ Other (Specify		ate DULA	NEY V	ALLEY MEM GARDENS	•	2/3/2	2004	TIMON	IUM, M	ח
Baltimore,	mit. I partm sortai y inju		21. Signature of Funeral Service Licer		P.W. P.V.	22							IOME, P.A.
œ	Depa Impo any ir		Rath N	Huj		8	521 LOCH	RAVEN	J BLV	D. TOWS	ON, N	1D 212	
	Physician		23a/Pax1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on eac	ised the death th line.					respiratory arr		5	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed as the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequal as a consequal	uence of):							
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		h 2 Fetal	death 3	Ectopic pregnancy Other (specify)				230	. Date of deliv Month	ery Day Year
Records, P	quires that n signed b uld be deta	ρλ	Part II. Other significant conditions of	ontributing to dea	th but not resu	ulting in the ur	nderlying cause give	in in Part I.		23e. Did to			he cause of death?
000	law requiras as been si 2 should l	Completed	HIGH BLOOD	PRESSUA	E					24a. Was a	n 2	4b. Were auto	opsy findings available
æ	The lavate has	mo	HYPORLIPIDE	MIA						autops perfori		death?	mpletion of cause of 2 No
Vital	i cian: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						of Death	(Check only or			
of C	Attending Physician: r death. ector: After this certific. by the funeral director.	은	1 ☐ Yes 2 No	Hospital: 1 ☐ Inp		ER/Outpatien		4 🗀 1401	rsing Hom			Other (Special	(y)
n C	ing F	lo iii	27. Manner of Peath 1 Natural 5 □ Pending		Injury Day Year)	28b. Time of Injury	Work	?		8d. Describe h	w injury o	ccurred	
Division of	death ctor: / the	Icat	Accident investigation 3 Suicide 6 Could not be		I Injury - At ho	me farm etr	M 1 ☐ Y eet, lactory, office	res 2□N		81 Location (S	reet and N	lumber or Run	al Route Number.
<u>></u>	after Direction by	Certification:	4 Homicide determined	building	, etc. (Specify	7)	set, ractory, office		-	City or Town		DITIDOF OF FIDE	ar riodie rightber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the briner: On the bas and manne	is of examinat	wledge, death tion and/or inv	n occurred at the time vestigation, in my op	e, date and inion, deat	d place, a	nd due to the cod at the time, d	ause(s) an ate and pla	d manner as s ace, and due to	stated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	2/	_		29c. License			2	9d. Date s	igned (Month,	Dey, Year)
	- 4		- Chil	1/1	10		D3	3118	9		1/3	30/04	
	104,		30. Name and address of person who Micha J. M. Natolf	completed cause	of death (Item	23a) (Type,	Print) bods	- Ri	0, 1	BALTHO	e6,	MS	
	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 2 200	A. Reg	istrar's Signat	ture	et l				,		

		1	For Stete Registrer	Sta	ate of Ma	ryland /	•	artment				ental Hy	giene	004	02577
		_	I. Decedent's Name (First, Middle	, Last)								2. Date of Dea		Year	3. Time of Death
	siciar edica		BRUNELL	COLE	MAN							JAN	27	2004	5:12 M
	mine		a. Fecility Name (If not institution							Location of			4c. Cou	nty of Death	
					CEN					MOR					
Fune			5. Social Security Number	6. Sex 1 X M 2		(In yrs. last l	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day		9. Birthp	lace (State or Foreign etry)
Direct	tor		218-26-7440 Usual Residence of Decedent			74						JUL 15,	1929		MD
yland yland	4		10a. State 10b. County	_		10c. City, To	wn or Lo	cation						1	0d. Inside City Limits
Mar 9-4 st	1 3	ğ	MD	NA				BALTI	MORE						1 X Yes 2 □ No
th the or 28		5	Oe. Street and Number					10f. Zip					10g. Citizen	of What Cour	itry?
ath wi		5	1632 ASHBU	RTON	STREET					1216				SA	
or dez		<u> </u>	11. Marital Status	Ar	as Decedent E med Forces?		13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	cify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,	
36 safte	ı lü	D Y	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 (∏ Ye <i>s</i> 2 X N Yes, Give ear or Dates:	0		1 ☐ Yes 2	No 🖾	Specify:			Spe	cify: AFF	
1215-0036 within 72 hours after death with the Maryland ene. than "naturat', or Items 23a or 28e-f show than "not let show the annual benefited at	1 1	ב ב	15. Deceden			16	ia. Dece	dent's Usua	I Occupa	ition			16b. Kind o	AMER f Business/Inc	RICAN dustry
2 c a a	Lotologo C	<u> </u>	(Specify only highe: Elementary/Secondary (0-12)	st grade com	pleted)		(Give	kind of wor DO NOT us	k done d	uring mos	t of worki	ng			,
212 d with giene		5	8th		O	+)		LAI	ORE	?			C	CONSTRU	CTION
Maryland 21215-0036 td 2 should be filed within 72 hours at the and Mental Hygiene. T? is marked other than "natural", or treaumain avent than "natural", or		ׁ ע	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	(First, Middle,	Maiden Sum	name)	
Venta be riced by the best of		2	MCCUTCHEN	COL	EMAN						HANN	AH COL	EMAN		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 15 marked other than "natural", or Items 23a or 28e-1 show any injury or other trainmaits awant the Merical Frammer the rottled a			19a. Informant's Name/Relations	hip (Type, Pr	rint)	15	9b. Maili	ng Address	(Street a	ind Numbe	er or Rura	l Route Numbe	r, City or To	wn, State, Zip	Code)
and and m 27		_		STON (SISTER)		632			ON ST		BALTI		ME) 21	
altimore, mit. Pages 1 ar partment of Hea portent: If item	5	2	20a. Method of Disposition 1 ABurial 2 Cremation	3 □Remov	al from State	ceme	tery, crei	nsition (Nam	her place			ate		on - City or To	
Fag. Pag.			`4 □ Donation 5 □ Other (S			ARBUTI				PK.	2/3/			MORE, I	
Bal Departiment	000		21. Signature of Funeral Service	Licenson		•	22					LIE FUN	ERAL H	OME PA	
402		+	23a. Part1. Enter the disease, or	complication	ne that caused	the death D	o not en	638 N					LTIMOR	E, MD	21217 Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cau	ise on each lin	e. \	01100 0111	tor the mode	o or cynne	g, 30011 d3	cardiac c	1 Tospilatory all	1031,		Interval Between Onset and Death
Physici /Medio			disease or condition resulting in death)	a	Sep	515									
Examir				1	Due to (or als a	consequenc	e of):								
		<u> </u>	Sequentially list conditions, if any, leading to immediate	b. —	Due to (or as a	consequenc	e of):								
betu L			cause. Enter Underlying Cause (Disease or injury that initiated events	G.											
D, exec an an		E X	resulting in death) Last		Due to (or as a	consequenc	e of):								
8760, ate be executed hysician and harman transit		20		d											
diffical		ge -	IF FEMALE:												
O. Box the death cert y the attendin		ann	23b. Was decedent pregnant in the past 12 months?		yes, outcome ∈ □Live birth		th 3[⊒Ectopic pr	egnancy				1	Date of delive Month	ry Day Year
e dea		rnysicianimed	1 Yes 2 No		□Pregnant at □Unknown	time of death	5[Other (sp	ecify)					NOTAL T	ou, lou
cords, P.O. Box 6: w requires that the death certific been signed by the attending p			Part II. Other significant condition	ons contribut	ing to death by	it not resulting	in the u	nderlying c	use awa	n in Part I		23e Did to	bacco use c	ontribute to th	ne cause of death?
dS, ires t signe		6	0 -	HLUI	_	ic not room, in	, III (IIO U	noonying o	2000 9110		•			3 ☐ Prob	2.1
requebeen		Completed										24a. Was a			
Refav		Ē										autop perfor	sy	prior to cor death?	psy findings available mpletion of cause of
ial: The Tricate ficate	2		25. Was case referred to medica							00 81	- (D 4 b		2 No	1 🗆 Yes	2 X No
Division of Vital Records, to Attending Physician: The taw requires to after death. Directors After this certificate has been signed in the fundary director, name 2 should have the fine of the physician page.	מופרות	ă	examiner? 1 Yes 2 No	Hospita	al:	nt 2□ER/0	Outnation	nt 3□ DO	Othe			<i>(Check only o</i> ne 5 ☐ Resid		Other (Specifi	4)
P. S.			27. Manner of Death	28	a. Date of Injur	v 28b	. Time o		8c. Injury Work		-	28d. Describe h			′/
inding and including and inclu		<u>a10</u>	1 Natural 5 ☐ Pendir 2 ☐ Accident investi		(Month, Day	rear)	Injury	М		7 /es 2 🗆	No				
Visio Attendi Pr death.			3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		e. Place of Inju- building, etc	ry - At home,	farm, st	reet, factory	office		2	28f. Location (S City or Tow		mber or Rura	l Route Number,
telor saftered participa		ē			Ballolling, old	. (0,500)/									
lospi t hou tuner	i i	g	29a. Certifier 1 Certifyir (Check only 2 Medical	g Physician Exeminer: (To the best on the basis of	f my knowled examination	lge, deat	h occurred a	at the tim	e, date an	d place, a	and due to the ded at the time, d	ause(s) and	manner as st	ated.
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and it can be the funeral director. After this certificate has been signed by the attending physician and the forest of the physician and the forest of the physician and the forest of the physician and the forest of the physician and the forest of the physician and the forest of the physician and the forest of the physician and the forest of the physician and the forest of the physician and the p	nelidii.	Medical	one)	a	nd manner sta	ted.				number				ped (Month,	
5 ± 5 5	5		29b. Signature and title of certifie	(7)	-					7 G 9	5	4) /	77/) 4
2/		-	The state of the s		-w)	.) (=		1 (166				21/0	/ /
7			30. Name and address of person	wno complet	ted cause of de	eath (Item 23a	a) (Type, 1ER		1FT)// A	1	ENTE	Ρ		
	State	e .	31. Date filed (Month, Day, Year)	1711	32. Registra	r's ignature	IFK	CY /	161	1011		-2012			
Reg	gistra		FE	B 0 2	200	MARIAN.		A And	A.C.	1					

			1 = For State	State of Maryland /	Department of Health and Certificate of Death		2001 02570
	7	10	Registrar 1. Decedent's Name (First, Middle, La	st)	Continuate of Death	Reg. I	3. Time of Death
	Physici		ACTTA	20:1109		Month	2) 200 M
	/Medi Examir		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of De		4c. County of Death
	A decision to the same	~#	21TSILOLIS	Ans # 103	HRRY HALL	(BALTIMORE
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last.	birthday) If Under 1 Year If Under 24 H Yrs. Months Days Hours M.	n. (Month, Day, Yea	
	Director		Usual Residence of Decedent	24	110.	NASCH18	CUBANDALIN HHA
	yland		10a. State 10b. County	10c. City, To	own or Location		10d. Inside City Limits
	e Ma	ctol	MARYLAND BALLIN	norz Pz	RRY HALL		1 ☐ Yes 2 No
	vith th	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
	eath v	Funeral	8170715115 T	12. Was Decedent Ever in U.S.	31036	(Specific Vac or No	14. Race - American Indian,
10	fter deal	E	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White, etc.
036	72 hours after death with the Maryland natural', or items 23a or 28a-f show diral Examiner must be notified at	by	3 ☐ Widowed ♠ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: WHILE
21215-0036	be filed within 72 hours after death with the Marylan hal Hygiene. d other than "natural", or itams 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's E	ducation 16	Ga. Decedent's Usual Occupation (Give kind of work done during most of v	rorking 16b.	Kind of Business/Industry
121	within lene. than	I du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	0.0	
	filed v Hygie ther t		17. Father's Name (First, Middle, Last,		18. Mother's N	ame (First, Middle, Maid	en Sumame)
an	should be nd Mental marked o	To Be	SOLDARD AND	Resid Looks	Mari	An FRAC	0.70an == 1
Maryland	S D E E	Ε,	19a. Informant's Name/Relationship (Type, Print) 1	9b. Mailing Address (Street and Number or	Rural Route Number, City	y or Town, State, Zip Code) 21040
	1 and 2 Health a		KARLJ-LOLLIO		SO TRIMBLE FILL	OS DRIVE:	EOLE WOOD, MARVIAND
ore	of of		20a. Method of Disposition 1 ☐ Burial ②图 Cremation 3 ☐	nomo	of Disposition (Name of tery, crematory or other place)	Date 20c.	Location - City or Town, State
Baltimore,		L	'4 Donation 5 □ Other (Specif	N) - B=7	ALL PA S	ody Fo	COSTHUL MARZES
Bal	permit. Par Depirtmen Important: Any njury	1	21. Sign titre Euneral Service Licer	1588	22. Name and Address of Facility	I RUSCIT	S Classiff L
			23a, Part1. Enter the disease, or com	plications that caused the death. D	o not enter the mode of dying, such as card	ac or respiratory arrest	Approximate
	Dhusisian		shock, or heart failure. List only Immediete Cause (Final	one cause on each line.	Cillar Dilari	11/1/1000	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequence	ce of):	114 1011	10 MM
ı	Examiner		Opening Market Base and Million	· acute	Myo Cardial.	Infarct	YOU I HE
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence	pe of):		
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C			
8760,	rate be executed only sician and the burial-transit			Due to (or as a consequence	ae or).		
687	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edicai	```	d			
Box (leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	4		23d. Date of delivery
	death	sicia	in the past 12 months?	1 Live birth 2 Fetal dea			Month Day Year
P.0	that the de led by the a detached i	Phys	9 Unknown	9□ Unknown			
	res that	þ	Part II. Other significant conditions of	entributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
orc	w requir	eted	111100	11 HAZIGA			
3ec	9 L 8	Completed	IN Y !	CY TVVIS (VII		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
al	ician: The l certificate ha ector, page	e Co	25. Was case referred to medical			1 ☐ Yes 25 ☑ 1	
of Vital Records,	Physician: this certific ral director,	To Be	examiner?	Hospital:	Other	eath (Check only one) Home 5 Residence	6 □Other (Specify)
	ng Phy ter thi		27. Manner of Death		p. Time of 28c. Injury at linjury Work?	28d. Describe how in	
sior	Attending it death. ector: After by the fune	atio	Natural 5 Pending 2 Accident investigation	n	M 1 ☐ Yes 2 ☐ No		
Division	spital or Attending ours after death. Peral Director: After filled in by the funer	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	Hospital 24 hours a Funeral D		29a. Certifier + Certifying Ph	veicien: To the best of my knowled	lge, death occurred at the time, date and pla	and due to the source	(-)
	9 T 4 D 9	Medical		niner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death oc	curred at the time, date a	and place, and due to the cause(s)
37.1	To the within 2 To the complet	Me	29b. Signature and title of contifier	2)	29c. License number	29d. C	Pate signed (Month, Day, Year)
)	1	1	1 fall o	Man MAD.	00193	39 11/	29/04
	10		30. Name and address it person who	on pleted cause of death (Item 23a	a) (Type, Print)	1	1 1
	200		31. Date filed (Month, Day, Year)	32. Registrar's anature			
	Sta Registi		FFB	0 2 2014 Asses	& Aprile		
				V 70			

		•	1 - For Stete Registrar	State of Marylan		irtment <i>tificate</i>			nd Me		iene	2001	1 1257	0
	Physicia	an	1. Decedent's Name (First, Middle, Last) Christian	M. Chris	tianser					2. Date of Death Month	h Day	Year 2004	3. Time of Death	2
,	/Medic Examin		4a. Facility Name (If not institution, give s Edenwald		Clansei			Location of I	Death	211/	4c. (County of Deat Baltin	n	_
Ī	Funeral Director		5. Social Security Number 6. Sex 220–30–1399	7. Age (<i>In yrs</i> . 100	last birthday) Yrs.	If Under 1 Months		If Under 24	Hrs. 8	B. Date of Birth (Month, Dey, [an 8,]		9. Birtl	nplace (State or Foreign untry) Vorway	7
	the Maryland 28a-f show	Director	Usual Residence of Decedent		y, Town or Lo	cation Lngs M		S		10	On Citiz	en of What Co	10d. Inside City Limits 1 ☐ Yes 2 ※ No	
36	filed within 72 hours after death with the Maryland Hygiene. Hhe than natural, or Itams 23e or 28e-f show aft, to Macilcal Examiner must be notified at	by Funeral Dlr	28 Bradbury F	Road 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ②No If Yes, Give Year or Dates:	i .		211 ent of Hi fy Cuba		n? (Spec Puerto Ri	ify Yes or No- ican, etc.)	U.	S.A. 4. Race - Ame Black, White	rican Indian,	
Baltimore, Maryland 21215-0036	be filed within 72 hours tal Hygiene. d other than "natural", evant, II e Madical Ex	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation		lent's Usual kind of work DO NOT use	done d retired	luring most o)	f working	9		ospital	ndustry	
yland	e da la be e	To Be (17. Father's Name (First, Middle, Last) Bertrand	Christianse	_		/2:		Guri			Unknow		
nore, Mai	jes 1 and 2 s of Health ar If itam 27 Is or other trau		19a. Informant's Name/Relationship (Ty, Ellene Christianse 20a. Method of Disposition 1. Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	n Daughter 20b. F		Mill sition (Name natory or oth	ers e of her place	Mill			and	, MD 2	1053	
Baltın	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License		22	. Name and	Addres	1	1182	4 Reist	ers	town Ro		6
	Pnysician	3 4	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the deat e cause on each line.									Approximate Interval Between Onset and Death	
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):			71141					zuyni	
O. Box 6	it the death certific by the attending p tached for use as it	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pre					23	3d. Date of deli Month	very Day Year	
ords, P.	The law requires that the te has been signed by the age 2 should be detached.	by	Part II. Other significant conditions cor	tributing to death but not res	ulting in the ur	nderlying ca	use give	in in Part I.		23e. Did tob			the cause of death?	
Vital Records,		Completed								24a. Was ar autopsy perform 1 Yes 2	red?	death?	opsy findings available ompletion of cause of	1
ō	ding Phys h. After this funeral di	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		c. Injury Work	r: 4 Nursi	ing Home	Check only one 5 □ Resider Id. Describe ho	nce 6		ify)	
Division	i Sir fe	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	y) 					City or Town,	, State)		ral Route Number,	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical		sician: To the best of my knoner: On the basis of examina and manner stated.		estigation, i	in my op			at the time, da	ite and p		to the cause(s)	
)	6		30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type. I		27	835	7				27,2004 109(109 10	
	Sta Registr		JCHA SIMM 31. Date filed (Month, Day, Year)	3 n (n , 0) &2. Register's Signa 2004	SI 8		7 F	צמ רן ו	רו כ	an;	LI	11797	CUAND	1

Christiansen, Christian

		4	For State Registrer	State of Maryland / D	Department of He Certificate of D		ental Hygier	211115	02580
	_# #		Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
in.	Physicia /Medic		FRIO FRA	NK DOTY				29, 2004	12:30 P ^M
	Examin	0.0	4a. Fecility Name (If not institution, give s	treet and number)	4b. City, Town, or I	ocation of Death		4c. County of Death	
			Greater Baltimore	Medical Center	Towson	If Under 24 Hrs.	8. Date of Birth	Baltimore	place (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex	M 005	Yrs. Months Days	Hours Min.	(Month, Day, Ye	ar) Cour	ntry)
			Usual Residence of Decedent	001			J-4		r Ci Ci III (
	ahow and at	_	10a. State 10b. County	10c. City, Town	n or Location			1	0d. Inside City Limits 1 ☐ Yes 2 No
	Be-f a	octo	JUATUR BUTTIE	15 P	N ARM		40-	Citizen of Mines Court	
	with the secrit	ā	10e. Street and Number	71 1 00 S m	10f. Zip Code	1	log.	Citizen of What Cour	iuy :
	leath	Funeral Director	11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Decedent of His	panic Origin? (Spec	cify Yes or No-	14. Race - Americ	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic svent, the Medical Engineer must be notified at	by Fun	1 ☐ Never Married Married Married Divorced	Armed Forces? ↑ Sel Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cuban	, Mexican, Puerto P Specify:	lican, etc.)	Specify:	etc.
21215-0036	2 hou	ted	15. Decedent's Educ		Decedent's Usual Occupa (Give kind of work done du	tion		. Kind of Business/In	dustry
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	aring most or working	9	/ ***********	2
21	led willygier		17. Father's Name (First, Middle, Last)	-	DENESSITE	18. Mother's Name	(First Middle Main	SAUTIONS net	-renoly
7	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic avent, If a Mance.	o Be	TO CO	Date		T/ARA	Har	POLO	
ary	2 should and Men is marks eumatic	은	19a, Informant's Name/Relationship (Ty)	pe, Print) 19b	. Mailing Address (Street a	nd Number or Rural	Route Number, Ci	ty or Town, State, Zip	(Code) 3113
2	1 and 2 Health a em 27 is		JANET SCHEIM	LR 40	DIVOLUCE	AND DRI	VE PHE	all Kinz	CORLES
ore	ges 1 st of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 SCremation 3 ☐ R.	cemete	Disposition (Name of ry, crematory or other place	DI JAN-3	3te 20c	. Location - City or To	own, State
Saltimore,	Pages ment of lant: If it	15	` ↓ Donation 5 Other (Specify)	- B274	7. V. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	30	Hi Fo	RESTHILL	Marthan
Ball	permit. Pages Department of Importent: If if any injury or c		21. Signal te of Funeral Survice License	9	22. Name and Address	of Facility	1. IEUSO	CIE W	2001/000
34			23a. Part1. Enter the disease, or compli	cations that caused the death. Do	not enter the mode of dying	, such as cardiac or	respiratory arrest,	1211/11/21	Approximate
d.	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):)
	¥	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):				
1	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	·					
0,	cate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or as a consequence	of):				
8760,	physic the b	dical							
9 x	he death certific: r the attending pl ched for use as t	0	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy				23d. Date of deliv	ery
Box	that the death	Physician/M	in the past 12 months?	1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		····	Month	Day Year
P.0	at the by th	phys	9 Unknown	9□ Unknown			OO. Didash		be seened of death?
Division of Vital Records, I	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by	Part II. Other significant conditions con		n the underlying cause give	n in Part I.	1 1/	ø use contribute to t 2 □ No 3 □ Prot	pably 4 Unknown
eco	ne law rei has bee ge 2 sho	piet	Cene Brovns wear	ACUDENT			24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
E B		Con	CHRONIC OBSTRA	CTIVE DVIMON	MRY OFEN	f c	performer 1 Yes 2		2 No
Vit.	Physician: The rule certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2 ER/Ou	strations 3 DOA Othe	26. Place of Death		- C - Other (C-ee	
of		Ë,	1 Yes 2 No	28a. Date of Injury 28b.	Time of 28c. Injury	4 La riversing Flore	8d. Describe how	e 6 Other (Special onjury occurred	y)
ion	Attending Property of the funeral of	atio	1 Matural 5 Pending 2 Accident Investigation	(Month, Day Yeer)		es 2□No			
ivis	r Atte	rtific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, to building, etc. (Specify)	arm, street, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
Q	pital c	Cel	20a Cartifica	blains. To the best of best. d	a death accurred to the time	e data and store :	and due to the co	o(c) and manage as	tated
	To the Hospital or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical Certification; To		sician: To the best of my knowledg ner: On the basis of examination ar and manner stated.					
	To the within To the	Me	29b. Signature and title of certifier	to 10 am	29c. License	number	29d.	Date signed (Month,	Day, Year)
			> /www	W Y	D3	0433	JA	N, 50, 0	(UU T
	10		30. Name and address of person who co		(Type, Print) V CHARUES	S1 6	MOMITIMOR	ut mo	21204
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's signature	& Specia	P			

	State of Maryland / Department of Health Certificate of Deal	th	giene Reg. No. 2004 02581
	Decedent's Name (First, Middle, Last)	2. Dete of De	eeth 3. Time of Death
Physician	Marion Elizabeth Davis	Month	10 27 3004 12:15 dm
/Medical Examiner		, Town, or Location of Death	
Examiner	Franklin Square Hospital Center R	reedale.	Baltimore
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Und	nder 24 Hrs. 8 Date of Bir	th 9 Rirthplace (State or Foreign
Director	220-20-7312 1□ M 2⊠X 88 Yrs. Months Days Hour	urs Min. (Month, Da 03-13-	1915 Maryland
D >	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		and topide City Living
the Marylar 28a-f show notified at			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
vith the Ma or 28a-f s be notified Director	MD Baltimore Co. Middle River 10e. Street end Number 10f. Zip Code		10g. Citizen of What Country?
(0 after death with the Maryls or items 23a or 28a-f sho miret must be notified at Funeral Director	602 Lanotian Road Apt. B 21220		USA
ofter death vitter death vittems 23 niver must	-	Origin? (Specify Yes or No	
aftar of the reference	Armed Forces? If Yes, specify Cuban, Mexi		Black, White, etc.
C 2 s	3 Notice of the second of the	city:	Specify: Black
121215-01 121215-01 ed within 72 ho rygiene. nor than "nature nor than "nature of the medical	15. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grede completed) (Give kind of work done during m	most of working	16b. Kind of Business/Industry
Ten ithin	Elementary/Secondary (0-12) College (1-4or 5+)		
nd 212 nd 212 nd lygiene, ont, the	7th Grade Custodian		Balto Co Public Schools
		lother's Name <i>(First, Middl</i> e, Ida Mae Joh	, Maiden Sumame) INSON
larylan 2 should be and Mental s marked o sumatic eve			
2 2 2 2 2	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Nur</i>		
re, M	Mildred Gardener/Sister 1000 Hillpine Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
7 0 8 0 E F	Laborial 2 Cremation 3 Premoval from State		
	4 Donation 5 Other (Specify) Holly Hill Mem Garde 21. Signature of Funeral Service Liperites 22. Name and Address of Fa		Middle River, MD
Balti Deemit. Departm importate any Injur	William C Bro	own Community	Funeral Home, P.A.
DESCRIPTION OF THE PERSON OF T	23a. Part1. Env. the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on eech line.		rrest, Approximate Interval Between
68760, filter be executed physician and as the bunal-transit edical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Sep515 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of):	onia	
Box 6 leath certific attending p f for use as	d		
	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pa	art I. 23b. Did	tobacco use contribute to the cause of death?
15, P.O. res that the de signed by the be detached by the by the be detached by Physician by Phy	Myocardial Infarction	10	Yes 2 No 3 Probably 4 Unknown
raqui been should	Myocardial Infarction Brest Cancer	24a. Was perfo	an autopsy rmed? 24b. Were autopsy findings available prior to completion of cause
Re(he lave he has age 2		101	of deeth? Yes 2 No 1 □ Yes 2 □ No
Vital I Iclan: The certificate rector, pag	25. Was case referred to medical 26 Pla	Place of Death (Check only of	
of Vi hysicia his cert if direct	examiner?		dence 6 □Other (Specify)
sion of Vital Remaing Physician: The I sath. for: After this certificate he tha tuneral director, page cation: To Be Com	27. Manner of Death 28e. Date of Injury 28b. Time of 28c. Injury et		how injury occurred
ision ttending I daath. ctor: Atier y tha funei fication	2 Accident investigetion M 1 ☐ Yes 2	2 □ No	
Divis at or Atte s after da i Directo d in by the	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (\$ City or Tox	Street and Number or Rural Route Number, vn, State)
Division of the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t complataly filled in by the funeral Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date of the control of t	and place, and due to the death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To the compla	29b. Signature and title of certifier 29c. License number	per	29d. Date signed (Month, Dey, Yeer)
	1 -58	8010	ular lau
5	30. Name end address of person who completed cause of death (Item 23e) (Type, Print)		- 19 + 104
	Dr. Kenneth McDowell, 9000 Franklin Squarel	Drive Balti	more MD. 21237
State	31. Date filed (Month, Day, Year) 732. Registrer's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Me	ntal Hygier	ne ₂₀₀₁	02582
			Registra AMEND TIEMFI/ PER FH G828 2/02/04 JR FRINCATE OF Death	Reg. I	No.	3. Time of Death
g	Physicia /Medic			Month [Day Yeer 2004	1-21-11
	Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	
			Union Memorial Hospital Baltimore		WIA	_
	Funeral Director		5. Social Security Number 6. Sex 157 M 2 F 7. Age (In yrg last binhday) If Under 1 Year If Under 24 Hrs. 8 Yrs. Wonths Days Hours Min.	Date of Birth Month, Day, Yes	9. Bir	thplace (State or Foreign ountry) Carolina
	D		Usual Residence of Decedent	47 / /	10 1001	PIN CAPOTINA
	arylan show	١	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 🟋 es 2 □ No
	28a-f	Director	10e. Street and Number 10f. Zip Code	100 /	Citizen of What Co	
	death with the Maryland ime 23s or 28s-f show rmust be notified at		2501 Violet Ave 21215	l og. (U.S	Ä.
	eme 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Vision of Marital Status) 14. Was Decedent Ever in U.S. It is a specify Cuban, Mexican, Puerto Richert Status of Marital Status	fy Yes or No-	14. Race - Ame Black, Whi	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar leatment of Heatth and Mental Hygiene. ortent: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f show injury or other traumatic event. It we Medical Exantinet must be rediffed at 8.	by	1 Se Never Married 2 Married 1	J. J. J. J. J. J. J. J. J. J. J. J. J. J	Specify: 12 1	ack
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b.	Kind of Business	
21	within ene. then	mple	Elementary/Secondary (0-12) College (1-4or 5+)		r1 ·.	L
	filed with Hygiene other the		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	First, Middle, Maid	en Sumama)	1
Maryland	ouid be I Mental Marked o	To Be	Mice T	Durham	,	
lary	2 shou and M is man	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural F	Route Number, City	y or Town, State, .	Zip Code)
	1 and 2 Health lem 27 i		Lee Hall Friend 1605 Argume Drive	Ball 1	rd. 21	215
Baltimore,	Pages 1 nent of H int: If ite iry or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	9 20c.	Location - City or	Town, State
äĦ	permit. Pages Depertment of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	2004 P	Service	0. PA.
ä	Depe impo any ir		Carlon C. Danfan Carlon Carlon St.	Bald	service. Les. 2	1217
	· .		23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Cardio my opathy			Onset and Death 5 years
H	/Medical Examiner		Due to (or as a consequence of): Atherosclerotics Cardiovascula	v dica		19 110000
	· · · · · · · · · · · · · · · · · · ·	Jer	if any, leading to immediate Due to (or as a consequence of):	· cusea	15e-	19 years
	acuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c			
60,	ficate be executed physicien and is the burial-transit	E	resulting in death) Last Due to (or as a consequence of):			
68760,		edlcal	d			
Вох	attending for use a	Z/M	IF FEMALE: 23b. Was decedent pregnant 1		23d. Date of de	livery
O. B	res that the death cer igned by the attendir be detached for use	Physician/M	in the past 12 months? 1		Month	Day Year
P.0.	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
rds,	The law requires that the death cert ite has been signed by the attending rage 2 should be detached for use	ed by	Diabetes Mellitus	1 ☐ Yes	2 ₽ No 3□Pr	obably 4 Unknown
SCO	law requir as been si 2 should	Completed		24a. Was an	24b. Were au	itopsy findings available
- E	iclan: The lar certificate has rector, page 2	Com		autopsy performed? 1 Yes 2	death?	completion of cause of
Vita	iclan: sertific ector,	Be	25. Was case referred to medical examiner? Hospital: Other			
ot	Phys r this ral dir	٦. ح	1 Prinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home	5 Residence		cify)
on	nding F ath. r: After e funer	atlor	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury M 1 ☐ Yes 2 ☐ No		,,	
Division of Vital Records,	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Suiside 6 Could not be	. Location (Street a City or Town, Sta		ıral Route Number,
	pital ours a erai D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	t due to the sever	(a) and manage	
	To the Hospital within 24 hours a To the Funeral completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	nd place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number		ate signed (Mont	
•	į		Larange garageras MD D59027	JAN	WARY 2	9 2004
	H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAVANYA YARLAGADDA, MD 201 EAST UNIV- PARKWAY	BALTIN	MORE	MD 212.12
	l l			0/10/11	IURIE !	10 21210
*	Sta	te	31. Date filed (Month, Day, Year) Segistrar's Signature			

		-	for Amend Item 24a pe State Registrar		02702764RR Ce	artment of F ertificate of	lealth a <i>Death</i>		Reg. No.			583
Dh	ysicia	_	1. Decedent's Name (First, Middle, Last,		. o r	EFFING	ED	2. Date of Month	Day		3. Time of	
	/edic	al -	DOLORES	CECIL	IA L			10	22	200		A W
Ex	amine	er	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location o		i	County of Dea		
			5. Social Security Number 6. Sec		(In yrs. last birthday						thplace (State of	or Foreign
Fun Direc			219-18-2515]м 2∏ F	78 Yrs.	Months Days	Hours	Min. July	9°, 1°92	5 Mar	yland	,, or or g,
and	-		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside Ci	ity Limits
Maryl f sho	a Dai	ğ	MD N/A		Baltimore	۵.					1 TyYes	2 🗌 No
the	100	rec	10e. Street and Number		Dar Gring,	10f. Zip Code			10g. Cit	izen of What Co	ountry?	
h with	1	a O	5207 Harford Road	Apt.2		21214	4		υ	.S.A.		
Baltimore, Maryland Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than "netural", or Items 23e or 28a-f show	Examinerna	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Norriced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 💢 No		gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify:		
Z1Z15-UU36 ad within 72 hours af rgiene. er than "natural", or	he Medical	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5-	(Giv	edent's Usual Occup e kind of work done DO NOT use retire Homemake)	during most d)	of working		ind of Business Own Hom		
Maryland 2 nd 2 should be filed lith and Mental Hygi 27 is marked other	atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Frank J. Walters				18. Mother	<u> </u>	dle, Maiden	Sumame)		
Mar nd 2 sho alth and 27 is m	rtraum		19a. Informant's Name/Relationship (T) Linda Lee Deems -		- 1			r or Rural Route Nui Norri svi				
F Hea	othe		20a. Method of Disposition		20b Place of Disc		T	Date	_	ocation - City or		
Page ento	ry of		1 ☐XBurial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		Holy Ros	sary Ceme	tery 1	/27/04	Bal	timore,	Maryla	ınd
baltimore, permit. Pages 1 and Department of Healt important: If item 2	eny inju		21. Signature of Funeral Service Licens	-Heather	Cain			, Leonard Road Balti				4
Physic /Med			23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	the death. Do not ere. The second consequence of):	•	N				Approximat Interval Bet Onset and I	tween
Exami	٥,	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):	0	se	Ena terba	tion			
cale be executed physicien and	e burial-trans	icai Examiner	Cause (Disease or injury that indicated events resulting in death) Last	Total Control	um n'a a consequence of): y deativ							
death certified attending	detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnance □ Other (specify) _	у			23d. Date of de Month		Year
ecords, P.O. law requires that the as been signed by th	pe q	ρχ	Part II. Other significant conditions co	4 1 1 5		underlying cause giv	ven in Part I.				o the cause of d robably 4 🔲	
* 9 4	page 2	Completed						. pe	fas an utopsy enformed? s 2X No	24b. Were as prior to death?	utopsy findings completion of c	available ause of
VITAL P lician: Th certificate	diractor,	Be (25. Was case referred to medical examiner?	to what we will				of Death (Check on	ly one)			
		ို	1 □ Yes 2 No	lospital: 1 Inpatier		AU TON		rsing Home 5 R			cify)	
UIVISION OT VITAL for Attending Physician: 1 after death. Director: After this certificat	ie funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time (Year) Injury	Wor	ryat rk? Yes 2∐1	28d. Descrit	oe now injur	y occurred		
DIVISION OF To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this	ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At home, farm, s . (Specify)	treet, factory, office			n (Street an Town, State		ural Route Num	iber,
To the Hospitel o within 24 hours af To the Funeral D	letely fil	edicai	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	sician: To the best oner: On the basis of and manner sta	examination and/or i	ith occurred at the til nvestigation, in my o	me, date and opinion, deat	d place, and due to t th occurred at the tim	he cause(s) ne, date and	and manner as I place, and due	s stated. e to the cause(s	s)
To th within To th	сошр	Me	29b. Signature and title of certifier	ſ .		29c. Licens	se number		29d. Dat	e signed (Mont	th, Day, Year)	
			1 Cyrille	Residen	t Physica	m) RE	0 23	000	0	1/22/0	γe	
3		-	30. Name and address of person who co	ompleted cause of de	(an Huse	173L	BALTIM	ORE.	NO à	21239	
	Sta	-	31. Date filed (Month, Day, Year)	32. Rasistra	r's Signature	hoard :			[

			For State		aryland / Dep	artment of	Health and	Mental Hygier	_	. 0250
			Registrar		Ce	rtificate o	T Death	Reg. I	No. C. UUI	+ 0230
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last Tohy 4a. Fecility Name (If not institution, give	E	vans	4b. City, Town	n, or Location of Dea	Takeary	Day Year 29 200 4c. County of Dee	3. Time of Death
	Funeral		Mercy Medic 5. Social Security Number 6. S		(In yrs. last birthday	Bold If Under 1 Year Months Day		. 8 Date of Righ	City	Thplece (State or Foreign
	Director		Usual Residence of Decedent	∑ M 2□F	65 Yrs.		75 Hours War	Feb. 18, 19	38 Mar	yland
	e Marylai Ba-f ehow	Funeral Director	MD 10b. County N/A		10c. City, Town or L Baltimor					10d. Inside City Limits
	with the or 20	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	leath rs 23	erai	5706 Arnhem Road	12. Was Decedent 6	Ever in U.S. 13.	Was Decedent of	21206 of Hispanic Origin? (5	Specify Yes or No-	U.S.A.	erican Indian,
	72 hours after death with the Maryland natural', or Items 23e or 28e-f ehow deal Examiner must be notified at	by Fur	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give X Year or Dates:	lo	If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	to Rican, etc.)	Black, Whi	
21213-0000	within 72 h ene. than "natu he Medical	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) Coltege (1-4or 5	(Giv	DO NOT use reti	ne during most of wo ired)	rking 16b.	Kind of Business	/Industry
7	e filed with Hygien other the		10			Disabled			N/A	
	Mental Mental arked o	To Be	17. Father's Name (First, Middle, Last) Alfred Evans	Euro (Grint)	105 14-1	Add (64-	Cather		ell	
	1 and 2 sho Health and Iom 27 io m other troums			rother	5706	Arnhem	Road Balt	ural Route Number, Cit Limore, Mary	yland 21	206
Daiminore,	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Disp cometery, cre Sacred H		Jesus 2/2		Location - City or altimore	Town, Stete , Maryland
2 2 2	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licen	see Fleather				eonard J. I Baltimore	Ruck, In	C.
F	Physician /Medical		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each line	the death. Do not er e.	ter the mode of d	lying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
,007	ate be executed whysician and the burial-transit	dical Examiner	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Tokic	a consequence of):	edun				
	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pregnar ⊒ Other (specify)	ncy		23d. Date of de Month	livery Day Year
623	jures that the signed by ald be detacted	by	Part II. Other significent conditions of	. 7 .	ut not resulting in the o				o use contribute to	o the cause of death?
Alter Heeel as,	The law requir cate has been si page 2 should I	Completed	Ling Conc	er .	1/2000			24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
		BeC	25. Was case referred to medical examiner?				26. Place of Dea	1 Yes 2 ath (Check only one)	√o 1 ☐ Yes	2000
5	Physician: this certific ral director.	To	1 ☐ Yes 2 2 20	Hospital: 1 npatier		III JU DON		fome 5 ☐ Residence	6 ☐Other (Spe	cify)
	The view of the v	ation:	27. Manner of Death 1 Adatural 5 Pending 2 Accident investigation		y Year) 28b. Time of Injury	W	jury at lork? □ Yes 2 □ No	28d. Describe how in	ury occurred	
	tal or Attend is after death el Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	Iry - At home, farm, st (Specify)	reet, factory, offic	0	28f. Location (Street: City or Town, Sta	and Number or Ru ite)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b	Medical	29a. Certifier (Check only one) (Check only one)	ysician: To the best on niner: On the basis of and manner sta	examination and/or in	th occurred at the evestigation, in my	time, date and place y opinion, death occu	a, and due to the cause urred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the To the complet	¥	29b. Signature and title of certifier	X1122	1 11.0	29c. Lice	nse number	29d. C	Date signed (Mont	h, Dey, Year)
	m		30. Name and address of person who	completed cause of de	eath (ttem 23a) (Type	Print)	30	1 Str 180	el Pla	ice a
	Sta Registr		31. Date filed (Month, Day, Year)	2 2004 Registra	CLI YLOU	COSTO	utes [salomo	le, he	D LBOS

		•	1 - For State Registrar	State of Maryland		artment of Hertificate of L			giene Reg. No. 2	004	02585
	Dhunini		1. Decedent's Name (First, Middle, La.	st)				2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medio		RUTH	ETZEL				JANUARY	27,	2004	10:50 A.M
	Examir	er	4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or		Death		nty of Death	
			MARINER HEALTH O 5. Social Security Number 6. S		t hirthday)	FOREST	HILL If Under 2	4 Hrs R Data of Rid		HARFOR	
	Funeral Director		S. Social Security Number 6. 3	□M 2MF	Yrs.	Months Days	Hours	Min. 8. Date of Birt		Cour	place (State or Foreign htry)
			Usual Residence of Decedent	/				0.00	- 10	Heu	901 PC.
	ryland how		10a. State 10b. County	10c. City, 1	Town or Lo	cation				1	0d. Inside City Limits
	e Ma	Director	MD Harto	ROL	Be	1 HiR					1 □ Yes 2 No
	ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	ath w	ral	115 C. DONZ		1.0	21		2/2	(JOH	
	ltem:	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No	13.	Was Decedent of His I Yes, specify Cubar	spanic Origi n, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	14. H	lace - Americ Itack, White,	
39	Irs af	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Spec	city: Lich	rite.
21215-0036	77 hours after death with the Maryland "natural", or liems 23a or 28a-1 show edical Examinating truffilled at		15. Decedent's Ed	ducation		dent's Usual Occupa		- Constitution	16b. Kind of	Business/In	dustry
218	- E	Completed	(Specify only highest gra	College (1-4or 5+)	lite.	kind of work done do DO NOT use retired)	uring most	of working	0	2	^
21	77	Son	12.		Sec	retary			Secr	etas	ial.
and and	Z E D	Be	17. Father's Name (First, Middle, Last,	1 11		-		s Name (First, Middle,	Maiden Sum	ame)	
ž	Me Aria	2	19a, Informant's Name/Relationship (Print!	10b Maili	Address /Street	He	or Rural Route Number	<u>onn</u>	· Chata 7:-	Codel
Maryland	d 2 7 Is		Man R Et	701	190. Maili	1	C2 11	Roll	A -	wn, State, Zip	0.160.14
	s 1 and if Health Item 27 other tr		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of	en	Darie	20c. Location	n - City or To	own, State
altimore,	0 0 = =		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif	Removal from State	etery, cre	natory or other place	001+	1-28-04	Faces	+ 14:1	am 1
Ħ	그 든 큰 글		21. Signaturejot Funeral Service Licer		S + U N	2. Name and Address					HILL, MD
ä	Depariment of the permit of th		Himberly	1). Zewrota	1 FL	MAIS FLLA	EPAI		BELI		
ŀ	* =		23a. Part 1. Enter the disease or com shock, or heart failure. List only	plications that aused the death,	o not en	er the mode of dying	, such as c			11.5	Approximate Interval Between
1	Physician		Immediate Cause (Finat disease or condition	ner	1 m	endance :	. 1	ufund			Onset and Death
	/Medical Examiner	. 4	resulting in death)	Due to (or as a consequer	ce of):	1			- 5		
ĸ	LXammer	_	Sequentially list conditions, if any, leading to immediate	b							
Ţ	ted nsit	ulu	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	ice oi).						
_	al-tra	Examine	that initiated events resulting in death) Last	C. Due to (or as a consequer	nce of):						
8760	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	cal		d							
9	rtifical ng phy as th	Physician/Medi	15 55144 5								
Вох	leath certifica attending ph I for use as the	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance		Ectopic pregnancy			1	Date of delive	
	e dea the at	sic	in the past 12 months? 1 ☐ Yes 2 Ø No 9 ☐ Unknown	4 Pregnant at time of deat 9 Unknown	h 5[Other (specify)			ľ	Month	Day Year
P.0	that the de		Part II. Other significant conditions of	ontributing to death but not resulti	ng in the u	ndarlying cause give	n in Part I	23e Did to	bacco use co	antribute to th	ne cause of death?
ds,	signe d be (d by	leuten	onthibataly to abath but not rogalis		inderlying cause give	min an.		es 2 □ No	_	
Sor	w require been si should t	ete	Balan P					24a. Was			psy findings available
of Vital Records,	0 - 0	Completed	- Fremme					autop	sy med?	prior to cor	inpletion of cause of
ta	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical				26 Place	1 ☐ Yes of Death (Check only o	No No	1 🗆 Yes	2 No
<u> </u>	di S	0.8	examiner? 1 ☐ Yes 2 No	Hospitat: 1 ☐ Inpatient 2 ☐ EF	/Outpatier	at 3 DOA Othe	- V	sing Home 5 Resid		other (Specifi	()
	ding Ph h. After th funeral	n: T	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	b. Time o	28c. Injury Work	at ?	28d. Describe h	ow injury occ	urred	
Sio	Attending in death.	catic	2 ☐ Accident investigation	1		M 1 🗆 Y	es 2□N	0			
Division	al or Attendir after death. I Director: Af d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, tarm, str	eet, factory, office		28t. Location (S City or Tow		nber or Rura	l Route Number,
	Hospital 24 hours a Funeral C	ပိ	29a Certifier 1 Certifying Ph	ysicien: To the best of my knowle	das dast	n account at the time		since and due to the			
	Hospital 24 hours Funeral letely filled	edical	(Check only 2 Medical Exar	niner: On the basis of examination and manner stated.	and/or in	vestigation, in my op	inion, death	occurred at the time,	late and place	e, and due to	the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month,	Day, Year)
			154 0 <	9		03	322	53	JANUAR	~ 27	2004
	5		30. Name and address of person who	completed cause of death (Item 2)	За) (Туре,	Print)			- 1110/41	1-4	
	/		DONIDSDU	NN 615W.1	1 DEP	hail a	Belon				· · · · · · · · · · · · · · · · · · ·
100	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrate Signatur 2 2004	e Le	1.0.					
	ricgisti	4.1	FEB U	7 2004 - LESSON	SI	A CONTRACTOR OF THE PARTY OF TH					

		ŀ	. 101	partment of Health and Nertificate of Death		ene 2001	02586
	a		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physicia /Medic		Christopher Fincher		January	28 2004	1559 M
Ž	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Annapolis Will If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Aru	
П	Funeral Director		385-52-7203 1 M 2 □ F 52 Yrs.	Months Days Hours Min.	(Month, Day, \	Year) Coi	place (State or Foreign intry) higan
			Usual Residence of Decedent		pan. 7,	1752 HIC	IIIgali
	nylan thow	_	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	e Ma Be-1 s	cto	MD Anne Arundel Annapo	lis			1 ☐ Yes ŽXXNo
	vith th		10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	intry?
	s 23s	eral	2574 Hidden Cove 11. Marital Status 12. Was Decedent Ever in U.S. 13	21401	acifu Vac ar Na	USA 14. Race - Amer	ican Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or itams 23a or 28e-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Never in U.S. Armed Forces? 1 Never Status 1975–95	B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Rican, etc.)	Black, White	, etc.
2-0	72 ho netur	Completed	15. Decedent's Education 16a. Decedent's entry for the state of the st	edent's Usual Occupation	ina 16	6b. Kind of Business/l	ndustry
2	ithin 1996.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work . DO NOT use retired)			
2	led w lygier her th		4 Offi			U.S. Army	
Maryland	I be fi	Be	17. Father's Name (First, Middle, Last) Joe L. Fincher		e (First, Middle, Ma	aiden Sumame)	
Ž	d Me mark mark	丘		iling Address (Street and Number or Run	hitfield	City of Town State 7	in Code)
	nd 2 s lith an 27 is			4 Hidden Cove, Ann			<i>p</i> 0000)
ē,	s 1 ar f Hea item other		20a Method of Disposition 20b. Place of Dis			Oc. Location - City or 1	own, State
Ë	Page: ento nt: If		VABurial 2 Cremation 3 Hemoval from State		/2004	Arlington,	VΔ
Baltimore,	permit. Departm Imports eny inju			Name and Address of Facility Hardesty Funeral 12 Ridgely Avenue	Home, P.A	Α.	
			23a. Part1. Enter the disease or complications that ceused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
?	Pnysician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):				
	Examiner		Due to (of as a consequence of).				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	cuted nd ransit	Examiner	that initiated events c.				
Ö,	icate be executed physician and s the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):				
8760,	cate b	dlcal	d				
.O. Box 6	The law requires that the death certifinate has been signed by the attending lage 2 should be detached for use as	by Physiclan/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delik Month	rery Day Year
σ.	s that in the plant y Ph	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	icco use contribute to	the cause of death?	
of Vital Records,	quire an sig uld b	ed t	Non Hodakins Lymphoma		1 ☐ Yes	2 2 No 3 □ Pro	bably 4 Unknown
ပ္သ	e law re has bee ge 2 sho	Completed	3		24a. Was an autopsy	24b. Were aut	opsy findings available
Ě	The late had page	mo.		•	performe	ed? death? ☐ No 1 ☐ Yes	2 No
/ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?		n (Check only one))	
<u></u>	Physicien: this certificatal director, I	은	1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpat			ce 6 ☐Other (Spec	fy)
ŭ	ding P. After I	lon:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred	
Division	Attending r death. ctor: After by the tune	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Stre	et and Number or Rui	al Route Number
<u>S</u>	after after Dire	Certification:	4 Homicide determined 256. Flace of injury Actionic, farm, building, etc. (Specify)		City or Town,	State)	
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, de 2 Medicel Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cau red at the time, date	ise(s) and manner as e and place, and due	stated. o the cause(s)
)	To the within To the comp	M	29b. Signature and title of certifier	29c. License number	290	1/30/0	Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Typ	Anne Aradel	M.J.	cal (o.	ter'
	Sta Registr		31. Date filled (Myring) Pay Year 2004 Registrar's Signature	all .			

	the t	1 - For Amend Item #1 Registrar	State of Ma 9b per fh	ryland / Dep G828 2/8/	artment of F Atificate of	lealth and N Death		ene 3. No. 200	4 0258
Physic	ian	Decedent's Name (First, Middle, Las.	t)	En.		2 /	Date of Death Month	Day Year	3. Time of Death
/Medi	cal	MATTHEW		71418	DENBE	-	JANUAR		
Exami	ner	4a. Facility Name (If not institution, give	street and number)	ten tah	11 11.	r Location of Death	Li	4c. County of De	ath N/A
Funeral		5. Social Security Number 6. \$\frac{4}{216-39-7864}	x 7. Age	(m yrs. last birthday) 10 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8 Date of Birth Month, Day, JULY 24	(ear) 9. B	irthplace (State or Foreign
Director		Usual Residence of Decedent	^	10 113.			JULY 24	,1993	MD
arylan show	٦	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
the M 28a-f	recto	MD HOWA	KU	CUL	UMBIA		100	g. Citizen of What C	1 Yes 2 No
h with 23a or	0	6987 NEWBERRY DR	IVE			21044	101	U.S.A	·
is 1 and 2 should be tiled within 72 hours after death with the Maryland of Health and Mental Hygiene. Hem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantinat must be rediffed at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	E .		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	terican Indian, ite, etc.
2 hour		15. Decedent's Edi	ucation	16a. Dece	dent's Usual Occup		16	Bb. Kind of Busines	WHITE s/Industry
tiled within 72 hours at Hygiene. other than "natural", or ant, the Medical Evanti	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	life.	DO NOT use retired	during most of work	king	EDUCATION	•
id 2 should be tile Ith and Mental Hy 27 Is marked oth traumatic event	Be	17. Father's Name (First, Middle, Last) PAUL		FRIEDEN	REDC	18. Mother's Nam	e (First, Middle, Ma		IDCZENICO
2 should and Mer Is marke sumatic	7	19a. Informant's Name/Relationship (7)	ype, Print)				M a <i>l Pjo</i> uta Number, (City or Town, State	IPCZENKO Zip Code)
1 and 2 Health a em 27 ls		PAUL FRIEDENBERG	/ FATHER	098	NEMBEKK	Y DRIVE -	COLUMBIA COLUMBIA	N. MD 210	445 45
Dermit. Pages 1 a Department of Hez mportant: If Item nny injury or othe	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F			natory or other plac	(e)		c. Location - City o	r Town, State
permit. Pages 1 Department of H Important: If Ite any injury or ot once.		 4 □ Donation 5 □ Other (Specify) 21. Signature of Ineral Service License 		CHIZUK AM	UNO ARLIN			BALTIMO	
permit. Departr Imports any inji		> Acott M	· Wither			30		ON & BROS IKESVILLE	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the cause on each line	ne death. Do not ent					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a BOWEL	. Necre	515				Onset and Death
/Medical Examiner		resulting in deathy	HYPOTE	consequence of):					
	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. Due to (or as a r	consequeñte of).					48 Hours
ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	0.	EPILEP	nous				48 Hans
licate be executed physician and s the burial-transit			a Ghramosa	consequence of):	-14 Tes	MSLOU	RONL		48 HORES
tilicate ng phy as the	ledical		d. =					-	7,200
at the death certition by the attending trached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
res that igned by be deta	by Ph	Part II. Other significant conditions co.	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
w require been sig should b		LIVER FAILURE					1 🗆 Yes	2 □ ₩0 3□P	robably 4 Unknown
The larate has	Completed						24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of s 2 2 No
sicien: Th certilicate rector, pag	o Be	25. Was case referred to medical examiner?	lospital:		Othe	AP.	n (Check only one)		
for Attending Physicien: after death. Director: Atter this certific in by the funeral director.	1- 4	1 Yes 2 No							
tal or Attendi rs after death. el Director: A ed in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
To the Hospital or within 24 hours afte To the Funerel Dirt completely filled in h	edical	29a. Certifier Certifying Phy (Check only one)	sician: To the best of oner: On the basis of ex	camination and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occurr	and due to the caus ed at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner state	u	29c. License			. Date signed (Mon	
F > F 0		June 1.5	lun	1 < wi	Do	05565	9 Jan	Nuary 21	3 2004
7		30. Name and address of person who co	ompleted cause of deal	th (Item 23a) (Type,	Print) Wolfe S	- Ral	times 1	10 2121	8 .7
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's 2004	s Sonature	y Losu				

			1 - For State Registrar	State of Marylar	-		ealth and I		ene 1. No. 2001	+ 02588
1	Physici		Decedent's Name (First, Middle, La	SCES Gress				2. Date of Death Month	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, giv		(4b. City, Town, or BAI-17		-T	4c. County of Dea	
	uneral irector	:	5. Social Security Number 6. 5		/ast birthday)Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, y		thplace (State or Foreign ountry)
Maryland	f show	tor	10a. State 10b. County	10c. Ci	ty, Town or Loc	Liner				10d. Inside City Limits
h with the	23a or 28a-f show ust be notified at	Funeral Director	10e. Street and Number	4 for	Jul 14	10f. Zip Code	318	10g	j. Citizen of What C	ountry?
d 21215-0036 filed within 72 hours after death with the Maryland Honiane	Department of the state and marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Modical Extributer must be notified at once.	y Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		/as Decedent of His Yes, specify Cubar ☐ Yes 2 ☑ No		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036 Id within 72 hours af	an "natural	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give k life. D	ent's Usual Occupa ind of work done d O NOT use retired)	uring most of wor	king	b. Kind of Business	,
and 21	ed other th	Be	17. Father's Name (First, Middle, Last,		1-100.	58 W. 1 /8		ne (First, Middle, Ma		C ²
Maryland and 2 should be file	27 Is mark r traumatic	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street a	nd Number or Ru	FIRSON BOLLIANTE	City or Town, State,	
Baltimore,	ant: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif	Removal from State	Place of Dispos	ition (Name of atory or other place	P	Date 20	c. Location - City or	Town, State
Balti Permit.	any inj		21. Signature of Funeral Service Licer	aux	22. 5 E EA	Name and Address	s of Facility ()	ATTO AR -1.	lancis te	ne sal Admis
	sician ledical		23a. Part1. Enter the disease, or com shock, or heart failure. List only 4mmediate Cause (Final disease or condition resulting in death)	a. Due to (or is a consec	cer	r the mode of dying	, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death 6 Men 4/5
· · · · · · · · · · · · · · · · · · ·	aminer	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa, Obsesse of injury	b. Due to (or as a consec						
760, ite be executed	hysician and he burial-transit	cal Examiner	Causa (Disease of injury that initiated events resulting in death) Last	C. Due to (or as a consec	ruence of):					
	nding phys	ed	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy				23d. Date of de	livany
O. Box	ed by the attending ph detached for use as th	by Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown		Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
Records, P.O. Box 68 The law requires that the death certifica	been signed should be det	ted by P	Part II. Other significent conditions of	contributing to death but not res	ulting in the und	derlying cause give	n in Part I.	23e. Did tobac		o the cause of death?
Vital Records, sician: The law requires t	S C4	Completed						24a. Was an autopsy performe 1 ☐ Yes 2	prior to	utopsy findings available completion of cause of
/ita	certificate rector, pag	Be	25. Was case referred to medical examiner?	(Innaita)				th (Check only one)		
of Vital Physician:	this o aldire	2	1 ☐ Yes 2X No		ER/Outpatient		4 Nursing H	ome 5 Residenc	e 6 Other (Spe	cify)
Division Call or Attending Patter death.	tor: After the funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b		28b. Time of Injury		at ? es 2 □ No	28d. Describe how		_
DIVI	To the Funerat Director: completely filled in by the		4 Homicide determined		(y)		a date and place	28f. Location (Stree City or Town, S	State)	
Diy To the Hospital or within 24 hours afte	To the Funerat C completely filled	Medical	(Check only one) 2 Medicel Exer	niner: On the basis of examina and manner stated.	ition and/or inve	estigation, in my op	inion, death occur	rred at the time, date	and place, and due Date signed (Mont	to the cause(s)
T 3	000		Posalyn &	mergensus						
})		30. Name and address of person who Rosalyn Jucygens	omplete seuse of death (Iter	n 23a) (Type, P	rint)	bine co	P 101 P	الا صعمال	21231
	Sta Registr	-	31. Date files (Month, Day, Year)	32 Tiogistial a Signa	iture	MAN PLOT	INIO CK	-100 D	LITHNITE N	aryiana

			1 - For State Registrar AMEND ITEM		-					d Mental Hy	giene Reg. No. 2	001	02589
	Physici	an	Decedent's Name (First, Middle Pau1				rdner			2. Date of De Month January	Day	2004	3. Time of Death 10:40 a ^M
,	/Medic		4a. Facility Name (If not institution,		or)	Ga.	4b. City, Tow	n. or Loca	ation of De			nty of Death	10.40 a
	Examir	ier	Anne Arundel	Z-,			Annapo					ne Aru	nde1
	Funeral			6. Sex 7. /		last birthday)	If Under 1 Ye	ear If U		in. 8. Date of Bir			place (State or Foreign ntry)
	Director		286-16-4839	10XM 2□F	82 8	33 Yrs.	Months Da	ays Ho	ours IV	Dec. 2,	1921	Ohi	O
	g		Usual Residence of Decedent		100 Cit	y, Town or Lo	anting.						10d. Inside City Limits
	aryla shov	7	10a. State 10b. County										1 X Yes 2 No
	Ba-f	ectc		Arunde1	Ar	napol	LS 10f. Zip Coo	4.			10g. Citizen	of Miles Cour	
	with t	by Funeral Director	10e. Street and Number	D .							•		ntry ?
	s 23	era	1176 Idylewild	12. Was Deceder	at Ever in II	S 13 1		1401	ic Origin?	(Specify Yes or No		JSA Race - Americ	can Indian
	item item	Š	11_Marital Status 1 Never Married 2 Marrie	Armed Force	s?		If Yes, specify (Cuban, Me	exican, Pu	erto Rican, etc.)		Black, White,	
986	urs af	by	3 ☐ Widowed 4 🋣 Divorced	ed 1 X Yes 2 [If Yes, Give Year or Dates	. WWII	Ε	1∐ Yes 2ŌX	No Sp	ecify:		Spe	cify:	White
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-1 show the Medical Exercise trust Lecristified at	ted	15. Decedent	s Education			dent's Usual Oc kind of work do		most of	unrting	16b. Kind o	Business/In	dustry
2	thin 7 8.	ed.	(Specify only highes Elementary/Secondary (0-12)	College (1-4c	r 5+)	life.	DO NOT use re	otired)	j most or t	WOIKING			
7	ogien er th	Completed		5+		Progr	ram Dir					S.A.	
פ	al Hy al Hy doth	Be	17. Father's Name (First, Middle, L					18.		Name (First, Middle,		ате)	
yla	Ment Ment arke	ဥ	Roy L. Gardner							abeth Eva	. — —		
<u>lar</u>	2 short	8 9	19a. Informant's Name/Relationsh		-		•			Rural Route Number			,
<u>~</u>	and lealth m 27 her t	١,	Jeannette D. B	arbera (Pei		The second second second	Ldylew sition (Name o		rive	Date Date) 2140. n - City or To	
0	ges 1 It of F If ite or ot		20a. Method of Disposition 1XX urial 2 ☐ Cremation		te C	emetery, crer	natory or other	place)					
Baltimore,	t. Pa rtmen rtant: njury		'4 □Donation 5 □Other (Sp		Mar		Vet. C			4/2004	Crowns	ville	, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Evan free must be retified at ODGs.		21. Signature of Funerat Service L	Clare-	-	22		ty Fu	ınera	1 Home, P		vm 01	.01
			23a. Part1. Enter the disease, or	complications that caus	ed the death	n. Do not ent				ue, Annap		MD 212	Approximate
)	Physician /Medical		shock, or heart failure. List of tmmediate Cause (Final disease or condition resulting in death)	- Sep	કાંડ								Interval Between Onset and Death
	Examiner		,	Due to for a	as a consequ	uence of):							
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	ıs a consequ	uence of):			<u> </u>				
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
o,	an an irial-tr	Ex	resulting in death) Last	Due to (or a	is a consequ	uence of):					7.7		
8760,	tate be executed only sician and the burial-transit	dical		d								_	Misson .
9	entifica ing pl e as t	Med	IF FEMALE:								1		
Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1☐Live birth	2 🗌 Fetal	death 3	Ectopic pregna					Date of delive Month	ery Day Year
o O	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5∟	Other (specify	<i>'</i>)			4		
P. O.	that the death certific ed by the attending p detached for use as	Ph	Part II. Ather significant condition	ns contributing to death	but not resu	⊿fling in the u	nderlying cause	given in f	Part I.	23e. Did to	bacco use co	ontribute to th	ne cause of death?
ds,	Physician: The law requires that the death certific this certificate has been signed by the attending p rail director, page 2 should be detached for use as	Completed by Physician/Me	Houte mi	maraia	ul in	tarc	200			101	es 200/No	3 🗆 Prob	ably 4 Unknown
Ö	w req beer shou	iete		1		1				24a. Was	an 24	b. Were auto	psy findings available
Be	he lar e has	mc		3						 autop perfo 	rmed?	prior to con death?	mpletion of cause of
ā	ificate or, pe	e C	25. Was case referred to medical					26	Place of F	1 ☐ Yes Death (Check only o	200 No	1 🗌 Yes	2 No
5	ysicia s cer direct	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	tient 2 🗆 I	ER/Outpatien	t 3 DOA	Other		g Home 5 ☐ Resid		Other (Specifi	y) -
0	g Ph ler thi		27. Manner of Death	28a. Date of tr (Month, D	jury Day Year)	28b. Time of	28c. l	njury at Work?		28d. Describe h	ow intury occ	urred	
Ö	andin ath. or: Af	atlo	1	ation	, , , ,	()		1 🗌 Yes	2 🗌 No				
Division of Vital Records,	al or Attu	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	286. Place of t	ntury - At ho etc. <i>(Specify</i>	me, farm, str	eet, factory, offi	ice	_	28f. Location (5 City or Tox	Street and Nu m, State)	mber or Rura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (Physicien: To the best examiner: On the basis and manner	of examinat								
	Го th Mithin Го th	Me	29b. Signature and title of certifier	11			29c. Lic	ense num	nber		29d. Date sig	ned (Manth,	Day, Year)
			>//	IL M	D		D	55	18	7	1/3	1/04	/
			30. Name and address of person	no completed cause of	death (Item	23a) (Type,	Print)	N		1/1	1		(
	5		Aimoe	n MD	•	1	nne	A.v.	nde	Mrd	luca	(0	nter
	Sta Registr		31. Date filed (Month Day Bear)	2 2004 32. Rev	trar's Signat	ture	Louis 1						

M			1 = For Unpended Item#2 Registrar	State of N 3a,27,28a-f	larylar Per M	id / Depá E ,C828,2	rimer /18/0 tifica	t of F	lealth a Death	and M	lental Hy	giene Reg. No.	2004	02590
	1		Decedent's Name (First, Middle, La		-				-		2. Date of De Month		Year	3. Time of Death
	Physici /Medic		LaForest			Gil	lian	1			JANUAR		2004	9: 48 P ^M
المبار	Examin		4a. Facility Name (If not institution, giv	e street and numbe	r)		4b. City	, Town, o	r Location o	of Death		4c. 0	county of Death	1
			BON SECOURS HOSE						ORE C					
	Funeral		5. Social Security Number 6. S	ex 7.7		last birthday) Yrs.	Months Months	r 1 Year Days	If Under:	Min.	8. Date of Birl (Month, Da	y, Year)	Cou	nplace (State or Foreign untry)
	Director		220-64-8779 Usual Residence of Decedent		46	113.			<u>. </u>		05 07	57	<u> </u>	MD
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Many -f sh	to	MD NA		Ba.	ltimor	ce							1 🛣 es 2 🗌 No
	r 288	Director	10e. Street and Number				10f. Zi	p Code				10g. Citiz	en of What Cou	untry?
	23a c	a	2126 Koko Lane					2	21216	<u>, </u>			U.S.A	•
	r dea	Funeral	11. Marital Status	12. Was Deceder Armed Force	s?	.S. 13. \	Was Dece If Yes, spe	dent of H	lispanic Ori an, Mexican	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	- 1	 Race - Amer Black, White 	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3X□XVidowed 4 ☐ Divorced	1 ☐ Yes 2√ If Yes, Give Year or Dates	X 40		1 🗆 Yes	2 X No	Specify:			5	Specify: D	lack
21215-0036	ilied within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Exargrating Leundillad al	edt	15. Decedent's E		••	16a. Deced	dent's Usi	al Occup	ation			16b. Kin	d of Business/li	
15	n "na	piet	(Specify only highest gra Elementary/Secondary (0-12)		= E + \	(Give	kind of w DO NOT	ork done ise retired	during mosi d)	t of work	ing			curity
212	d with	Completed	12th grade	2yrs	3+)	Seci	urit	y Gı	uard			Age	гсу	
b	al Hyg	BeC	17. Father's Name (First, Middle, Last,								e (First, Middle,	Maiden S	lumame)	
<u>yla</u>	should be nd Mental nmarked c	To	Cecil L. Gillia	ım					Pear	1 L	ifsey			
a	2 sho and Is m		19a. Informant's Name/Relationship (-				al Route Numbe			_
e,	1 and Health em 27 thar tr		Pearl Gilliam- 20a. Method of Disposition	-Mother	20h F	2126 Place of Dispo			ane,		timore		2121 ation - City or T	
Baltimore, Maryland	permit. Peges 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: it Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exercites must be inclined at ance.		Valual 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specific	Removal from Star	te C	cemetery, crer	natory or	other plac						
ᆵ	urtment ortent njury		* 4 □Donation 5 □ Other (Specifical Service Licer		Ki:						80/04	Rand	dallst	own, Md
Ba	permit. Departr Import		Tala VI	March		Ma	arch	F/I	ss of Facility Wes	št	Balti	more	ьма	21215
			23a Part1. Enter the disease, or com	plications that caus	ed the deat								- 110	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	Narcotio		cication								Onset and Death
	/Medical		resulting in death)	a. Due to (or a										
	Examiner		Sequentially list conditions.	b										
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	juence of):								
	and and II-tran	хап	that initiated events resulting in death) Last	c. Due to (or a	as a conseq	juence of):								
8760,	certificate be executed ading physician and use as the burial-transit	dical E		4									Ì	
687	ificate g phy: as the	edic		0.										
Вох	eath certific attending pl	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Teatania i					23	ld. Date of deliv	very
	the atter the atter hed for u	Physician/Me	in the past 12 months? 1 \(\sum \) Yes \(2 \sum \) No	4☐Pregnant	at time of d		JEctopic (Month	Day Year
о <u>.</u>	by tac	Phys	9 Unknown											
Ś		by	Part II. Other significant conditions of	contributing to death	but not res	sulting in the ui	nderlying	cause giv	en in Part I.			obaccous ∕es 2 Д		the cause of death?
Record	law requires as been sign 2 should be	Completed									•			
3ec	e law has t	mpi									24a. Was autop		24b. Were aut prior to ci death?	opsy findings available ompletion of cause of
a	iician: The certificate hi rector, page										1 X Yes	2□No	1 X Yes	2 🗆 No
Vital	Physician: The raths certificate har all director, page	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	tiont 2	ER/Outpatien	1 2 FE	OA Oth	OF.		h <i>(Check only o</i> me 5 □ R esid		MOther (Case	
ō	무 무 등	n: To	27. Manner of Death	28a. Date of Ir	njury	28b. Time of		28c. Injur Wor			28d. Describe h			ny)
ion	Attending r death. ector: After by the fune	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	fotted ^{h, l}	Jay rear)	6:45	D M		k? Yes 2 X ∃	No	unknown			
Division	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ♣ Could not be determined		Injury - At h		eet, facto	ry, office			28f. Location (S City or Tox		Number or Rui	ral Route Number,
	ital or A			found a	t home						2126 Kok	o Lane	,Baltimo	re,MD
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Exer	nysician: To the be miner: On the basis	of examina									
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner	stated.		2	c. Licens	e number			29d. Date	signed (Month	, Dev. Year)
)	1 2 Z S		1 day 1 to 1	Shora h	one.	MA		_	CM	E			ARY 25,	
			30. Name and address of person who	completed cause of	death /lter	n 23a) (Tune	Print)							
			Tousha Z Gi	eenhei	RM	1 .D		111 F	enn S	tree	et, Balt	imor	e, Mary	land 21201
	-% Sta		31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	ature								
	Registr	ar	EED 0.9 2004			2	1							

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

JANUARY

KATHERINE

GORDON,

			For State Registrar	State o	f Maryland	-	artment of H tificate of L		and M		giene Reg. No.	2001	02	592
	Dhysisi		1. Decedent's Name (First, Middle	, Last)						2. Date of Dea Month	ath Day	Year		of Death
	Physici /Medic		Gerald Greens							January				3 AM M
	Examin	er	4a. Facility Name (If not institution		mber)		4b. City, Town, or		of Death		4c. (County of Dea		
			1574 Colora Roa 5. Social Security Number	a.C. 6.Sex	7. Age (In yrs. k	ast hirthday)	Colo	ra If Under	24 Hrs.	8. Date of Birt	h	Cecil		te or Foreign
	Funeral Director		107-26-0428	1∭ M 2□F	69	Yrs.	Months Days	Hours	Min.	June 1.	Year)	934	thplace (Sta ountry) New Yo	rk
			Usual Residence of Decedent								,			
	how		10a. State 10b. County		10c. City	, Town or Lo								City Limits
	Ba-fa	cto	MD C	ecil		Colo	ra						1	es 2X No
	Alth th	Director	10e. Street and Number 1574 Colora Ro	د .			10f. Zip Code	17			10g. Citiz	zen of What C	ountry?	
	s 23e	Funerai			edent Ever in U.S	5 12 1	219		ain? (Sne	ocify Van or No		USA 14. Race - Am	erican Indian	
_	ter d	Š	11. Marital Status 1 Never Married 2 Married	Amped Fo	rces?	1	Was Decedent of Hi f Yes, specify Cuba	n, Mexicar), Puerto I	Rican, etc.)		Black, Whi		1
2	ursal	þ	3 ☐ Widowed 4 🛣 Divorced	If Yes, Gi Year or D	ve 157-5	58	1 ☐ Yes 2X No	Specify:			- -	Specify: W	nite	
215-0036	I within 72 hours after death with the Maryland lene. I than "natural", or Items 23a or 28a-f ahow The Medical Examinar must be notified at	Completed	15. Decedent (Specify onfy highes	's Education			dent's Usual Occupa		t of workii	unk	16b. Kin	nd of Business	/Industry	unk
7	within ene. than "	ngie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)						
N	tiled w Hygler Sther tl	ខ	unk 17. Father's Name (First, Middle, I	unk				18 Mothe	r's Namo	(First, Middle,	Maiden	Sumama)		
and	e d ala) Be	Isadore Gr							nberg	THE CONTRACT OF THE	Jumamey		
>	d 2 should th and Men 7 is marke traumatic	၉	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street a				r, City or	Town, State,	Zip Code)	unk
Z	2 6 7 8		Arthur Greenspa											
ē,	一直商業		20a. Method of Disposition		1 00	ace of Dispo	sition (Name of matory or other place	e)	D	ate	20c. Loc	cation - City or	Town, State	
Ē	Pages nent of unt: If it ury or o		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 🗓 Other (Sp		State	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,	1						
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service I	11111 3	iregtor	St	Name and Address	omy B	oard			timore	Stree	t
П			23a. Part . Enter the disease, or shock, or heart failure. List	complications that	caused the death	. Do not ent	er the mode of dying	g, such as	cardiac o	r respiratory ar	rest,		Approxir	nate Between
	Priysician		Immediate Cause (Final disease or condition	Δ	on te	Ma	cardia	0	INF	acc. to	200			nd Death
	/Medical		resulting in death)	a. Due to	(or as a consequ		700700	St	- 1	J. 0 //				
	Examiner	L	Sequentially list conditions,	b. —		Albania de								
	ed isit	Examiner	Sequentially list conditions, tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cua to	(or as a consequ	ieuga orij.								
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to	(or as a consequ	ience of):								
3/60	ate be ex hysician he buria	dicai E		d										
8	titicate ig phys as the	ledi		1		_					1		0	_
ROX	eath certitic attending p	N/us	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnatoirth 2 Tetal		Ectopic pregnancy				2	3d. Date of de		V
	e deal he att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (specify)					Month	Day	Year
r Ö	nat the de d by the a letached t	Ph	9 Unknown Part II. Other significant condition	Be contributing to d	anth but not recu	dting in the u	ndarhúna nauca aive	on in Part I		23e Did to	hacco us	se contribute t	o the cause	of death?
Vital Records,	The law requires that the death certiticate be executed the has been signed by the attending physician and lage 2 should be detached for use as the burial-transitions.	ğ	Ity perte	u 570-		•	riderlying cause give		•		es 2□		robably 4	
Ö	w require been si should b	Completed	Dubecco	Abuse						24a. Was		24b. Were a	utopsy findin	gs available
Ä	The lavate has	mo	10000	100						autop perfor 1 Yes	med?	24b. Were a prior to death?	completion of a completion of	of cause of
<u>e</u>		a	25. Was case referred to medical					26. Place	of Death	(Check only o		1016	20110	
<u> </u>	Physici this cer al direc	To B	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	Inpatient 2 🗆 I	ER/Outpatier	nt 3 DOA Othe	er: 4 □ Nu	rsing Hon	ne 5 AResid	lence 6	Other (Spe	ecify)	
n of	ding Ph h. Atter th tuneral		27. Manner of Death 1. ■Natural 5 □ Pending	28a. Date	of Injury th, Day Year)	28b. Time or Injury	28c. Injury Work	at	2	8d. Describe h	ow injury	occurred		
<u>S</u>	Attandii death. ctor: Ai y the tu	catio	2 Accident investig	pation				Yes 2 □	-					
DIVISION	al or Attanos atter death	Certification:	4 Homicide determ	ined 289. Place	e of Injury - At ho ing, etc. (Specify	me, farm, str	eet, factory, office		12	28f. Location (S City or Tow			ural Route N	umber,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: Atter this certific completely liked in by the tuneral director,	edicai		g Physician: To the Examiner: On the b and man										e(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	10			29c. License	number		-	29d. Date	signed (Mon	th, Day, Yea	7)
			M. e.	14 /	agi	m	D-5	520	87	,	Jan	vary à	12, 2	W4
			30. Name and address of person	who completed cau	se of death (Item	23а) (Туре,	Print)					0		
			31. Date filed (Month, Day, Year)	reet E	Magistrar's Signal	Mary	land	2	192	-(
	Sta Registi			2004	Mada J	de sa	CONSTRUCTION OF THE PARTY OF TH							

Donna Guido 04-00768 MAN

		4. Department North Address 4	e1				2. Date of Dea	giene og. No. 200	14 025
Physicia	an	Decedent's Name (First, Middle, Las.					Month	Day Y	3. Time of De
/Medic	al	Donna Sue G 4a. Facility Name (If not institution, give	tract and number		4b. City, Town, or L	ocation of Death	January	4c. County of	
Examin	er	Johns Hopkins Bayt	•		Baltimo			4c. County of	City
uneral		5. Social Security Number 6. Se	7	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Birthplace (State or Fo
irector		213-13-6851 Usual Residence of Decedent	33	115.			July 12	, 19/0	Maryland
how		10a. Slate 10b. County		y, Town or Lo					10d. Inside City L
r 28e-f ehow Inotified at	Director	MD	В	altimo					1 ☑ Yes 2 [
a or 2 Lban		10e. Street and Number	1 4		10f. Zip Code 21222			U.S.A.	,
Items 23a	Funerai	6608 Holabiro	12. Was Decedent Ever in U.	.S. 13.	Was Decedent of His if Yes, specify Cuban,	panic Origin? (S	pecify Yes or No-		American Indian,
0 5	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:	i	1 Yes 2 No		o rican, etc.)	Specify:	White, etc. White
"netural",	Completed	15. Decedent's Ed.	ucation . de completed)	16a. Dece	dent's Usual Occupati kind of work done du DO NOT use retired)	ion iring most of wor	king	16b. Kind of Busin	ness/Industry
hen R Max	mple	Elementary/Secondary (0-12)	College (1-4or 5+)			•		Restau	rant
other in		10 th Grade 17. Father's Name (First, Middle, Last)		l W	aitress	18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	Tanc
arked c	To Be		Ronnie (n	Nan	cy Tynes		
item 27 is marked other then "netur other traumatic event, the Madical	() ()	19a. Informant's Name/Relationship (7 Ronnie Clifton	уре, Print) Father		ng Address (Street an ockeysmill				ate, Zip Code)
Important: If item 2 any injury or other once.	1	20a. Method of Disposition 1 Burial 2X Cremation 3 : 1 Donation 5 Other (Specify	Removal from State Care	Place of Dispo	sition (Name of matory or other place) I ema LIOn	1/3	1/04	20c. Location - Ci Hampst	ty or Town, Slate ead, Md.
lmporta any inju once.		21. Signature of Funeral Service Licent	see a fini		Name and Address	•		istersto	
edical iminer	1	resulting in death)	a. Cardiac arrhy Due to (or as a consequ						
	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary arte Due to (or as a consequence) Due to (or as a consequence)	це пса эї).	ase				
physicia the bur	dical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a conseque.	uence of): uence of): incy I death 3	ase Ectopic pregnancy Other (specify)			23d. Date of Month	,
physicia the bur	dical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): incy I death 3 [eath 5 [Ectopic pregnancy	n in Part I.		Month	Day Yea
ate has been signed by the attending physicial page 2 should be detached for use as the bur	Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): incy I death 3 [eath 5 [Ectopic pregnancy Other (specify) nderlying cause given		1 Ves	Month bacco use contributes 2 No 3 in print 24b. We print 1994 in 1994	Day Yea
certificate has been signed by the attending physicia rector, page 2 should be detached for use as the bur	Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a consequence) Due	uence of): uence of): incy I death 3[eath 5[ulting in the u	Ectopic pregnancy Other (specify) nderlying cause given	26. Place of Dea	24e. Was a autops perform Yes	Month bacco use contributes 2 No 3	Day Yea Je to the cause of deat Probably 4 Unk The autopsy findings avair to completion of caus The 2 No
tter this certificate has been signed by the attending physicial neral director, page 2 should be detached for use as the bur	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence. Due to (or as a consequence.)	uence of): uence of): incy I death 3[eath 5[ulting in the u	Ectopic pregnancy Other (specify) Inderlying cause given at 3 DOA Other B 28c. Injury & Work?	26. Place of Dea - 4 □ Nursing H	24e. Was a autopi perform the Check only or ome 5 Residue	Month bacco use contributes 2 No 3 in print 24b. We print 1994 in 1994	Day Yea Jay Yea
tter this certificate has been signed by the attending physicial neral director, page 2 should be detached for use as the bur	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significent conditions of Cocaine usage 25. Was case referred to medical examiner? 27. Manner of Death 1 Natural 5 Pending	Due to (or as a consequence) Due to	uence of): uence of): uence of): uency I death 3 [eath 5 [ulting in the u ER/Outpatier 28b. Time o Injury	DEctopic pregnancy Other (specify) Inderlying cause given Int 3 DOA Other B 28c. Injury a Work? M 1 Ye	26. Place of Dea 	24e. Was a autop: Derform Yes th (Check only or ome 5 Reside 28d. Describe he	Month bacco use contributes 2 No 3 In 24b. We prior to a prior to	Day Yea Jay Yea
tter this certificate has been signed by the attending physicial neral director, page 2 should be detached for use as the bur	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence) Due to	uence of): uence of): uence of): uence of): uency I death 5 [ulting in the u ER/Outpatier 28b. Time of Injury ome, farm, str	Dectopic pregnancy Other (specify) Inderlying cause given In 3 DOA Section 28c. Injury a Work? M 1 Ye eet, factory, office	26. Place of Dea 4 Nursing H at as 2 No	24e. Was a autop berform Yes th (Check only or ome 5 Residual 28d. Describe he city or Town	Month bacco use contributes 2 No 3 In 19 Property of the prope	Day Yea Day Yea Jay Yea
tter this certificate has been signed by the attending physicial neral director, page 2 should be detached for use as the bur	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence. Due to (or as a consequence.) Page 1 Due to (or as a consequence.) Page 2 Due to (or as a consequence.) Due to (or as a	uence of): uence of): uence of): uence of): uency I death 5 [ulting in the u ER/Outpatier 28b. Time of Injury ome, farm, str	Dectopic pregnancy Other (specify) Inderlying cause given In 3 DOA Section 28c. Injury a Work? M 1 Ye eet, factory, office	26. Place of Dea 4 Nursing H at es 2 No 0, date and place nion, death occu	24e. Was a autop: Derform Yes th (Check only or ome 5 Reside 28d. Describe his 28f. Location (S. City or Town), and due to the corred at the time, discounting the corred at the time, discounting the correct of the c	Month bacco use contributes 2 No 3 In 19 Property of the prope	Day Yea Jay Yea
fler this certificate has been signed by the attending physicia ineral director, page 2 should be detached for use as the bur	Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence. Due to (or as a consequence.) Page 1 Due to (or as a consequence.) Page 2 Due to (or as a consequence.) Due to (or as a	uence of): uence of): uence of): uncy I death 3 [eath 5 [ulting in the u ER/Outpatier 28b. Time o Injury ome, farm, str	Dectopic pregnancy Other (specify) Inderlying cause given at 3 DOA at 4 DO	26. Place of Dea 4 Nursing H at es 2 No o date and place nion, death occu	24e. Was a autop: Derform Yes th (Check only or ome 5 Reside 28d. Describe his 28f. Location (S. City or Town), and due to the corred at the time, discounting the corred at the time, discounting the correct of the c	Month bacco use contributes 2 No 3 In 19 19 19 19 19 19 19 19 19 19 19 19 19	Day Yea Jay Yea

			1 - For Amend Item 18,	State of Marylar per FH,G828,02/2	nd / Depa 29/04dbb Cer	rtment of H	ealth and Death	Mental Hy	giene 2	004	02594
			Decedent's Name (First, Middle, Las					2. Date of De		Year	3. Time of Death
	Physicia /Medic		Charles F. Hilber	rg, Sr.				01		2004	12:48 AMM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	th		inty of Deeth	
			St. Joseph's Med			Towson If Under 1 Year	If Under 24 Hr	S 0 0-11 -1 B:		ltimo	
	Funeral		5. Social Security Number 6. Se	ZIM 2DE	. last birthday) Yrs.	Months Days	Hours Mir	. (Month, Da	ay, Year)		nplace (State or Foreign untry)
hali;	Director		213–38–9114 Usuat Residence of Decedent	70				02/04/	1933	Ма.	ryland
	/land		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mar.	to	MD Baltin	more 1	Baltimo	re					1 ☐ Yes 2 🙀 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Co	untry?
	23a 23a ust b	ral	8932 Kilkenny Ci	rcle		21236			U.S.		
96	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23s or 28s-f show strain july or other traumatic event. The Medical Examinat must be maillist at ance.	by Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	'	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 【X No	ispanic Origin? (in, Mexican, Pue Specity:	Specify Yes or Norto Rican, etc.)		Race - Ame Black, White ecity:	e, etc.
8	ural'		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a Dagge	lent's Usual Occup	ation		16h Kind o	WIT of Business/l	ite
7	n 72 n "naf	Completed	(Specify only highest grad	de completed)	(Give	kind of work done of NOT use retired	during most of w	orking	TOD. KING C	7 503110334	industry
12	i withi	mo	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		nt Manage			Sol	id Wa	ste
D	Hyg other	a)	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·				ım <i>e (First, Middle</i>			
ılar	uld be Menta rked	To B	Frederick William	n Hilberg			Elsio	A. Bort	nek ^E	Elsie A	. Bortner
lan	and h		19a. Informant's Name/Relationship (7		19b. Mailir	g Address (Street	and Number or F	Rural Route Numb	er, City or To	wn, State, Z	Tip Code)
Σ,	and seatth m 27		Charlotte G. Hill			Kilkenny	Circle				
Baltimore, Maryland 21215-0036	ges 1 f of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crer.	sition (Name of natory or other place		Date		on - City or	
Ē	I. Par tmen tant:		'4 □ Donation 5 □ Other (Specify			el's Ch.					
Bal	Departing Department of the policy of the policy in the policy in the policy in the policy of the po		21. Signature of Funerat Service Licen	ssaln		1750 Bela					l Home, P.A. 21087
變			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea one cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Finat disease or condition resulting in death)	a. ACUTE 1	MYOCAR	DINL IN	FARCTIO	N			· MOH£
leg.	/Medical Examiner		resulting at death)	Due to (or as a conse	quence of):						
		-	Sequentially list conditions,	b. Due to for as a conse	quanta of).						
	uted	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć.	exec on and rial-tra	Exa	resulting in death) Last	Due to (or as a conse	quence of):						
8760,	death certificate be executed the attending physicien and ad for use as the burial-transit	dical		d							
9	ndiffica ing ph e as th	Med	IF FEMALE:			0.00					
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel	tal death 3	Ectopic pregnancy			23d.	Date of deli Month	very Day Year
<u>o</u>	the de y the a tched f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5∟	Other (specify)					
Δ.	res that the designed by the be detached	h h	Part It. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Vital Records,	Se Deg	d by						1 🗆	Yes 2XN	o 3 🗆 Pro	obably 4 Unknown
100	> 11 0	Completed						24a. Was		4b. W <i>ere</i> au	topsy findings available
Re	o	mo						auto perf 1 \(\sum \text{Yes}\)	ormed? 2. No	death?	completion of cause of
tal	icien: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of D	eath (Check only			
<u> </u>	g 78	ToB	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2	K ER/Outpati <i>e</i> r	t 3 DOA Cth	er: 4 🗆 Nursing	Home 5 ☐ Res	idence 6 🗆	Other (Spec	cify)
n of			27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe	how injury oc	curred	
Sio	Attending r death. ector: After	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No		/a:		
Division	in Pite	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office			(Street and Ni own, State)	umber or Hu	iral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (ysician: To the best of my kr niner: On the basis of examinand manner stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifier		· · · · · · · · · · · · · · · · · · ·	29c. Licens	e number		29d. Date si	gned (Month	h, Day, Year)
)			* CHYMD			D	26575		0	1-29-	2004
	15		30. Name and address of berson who		em 23a) (Type,		OCKEYSVI	LLE, MD	21030		
A	· Sta	ite	31. Date filed (Month, Day, Year)								
	Regist	rar	FEB 0 2 2004	32. Registrar's Sign	The state of the s	E.					

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 27 2004 11:05 pM ANSALLINA HORNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE JOSEPH RICHEY HOSPICE N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1□M 2⊠F 93 Yrs 15 1910 SOUTH CAROLINA Director 216-18-3253 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State rthan "natural", or Itams 23a or 28a-f show Its Madical Examiner must be rutified at 1 XYes 2 No MARYLAND BALTIMORE N/ADirect 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4728 DUNKIRK AVENUE 21229 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: BLACK \$ 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Itam 27 is marked other tha any injury or other traumatic event. It a 9th grade AMRAHEIM BAKERY 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) JANTE KING CHAPMAN BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie U. Urvin/Daughter 301 Lourerio Ln, Oxen Hill, Md., 20745 Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify)-ARBUTUS MEMORIAL 01-31-04 BALTIMORE, MARYLAND 21. Signature of Francis San de Meens 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part / Errer the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Dement years **Physician** /Medical Due to (or as a consequence of) Examiner Cerebro Vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed? Yes 2 No 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1050 icl 1 Yes 2 No 10 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Diractor: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital e within 24 hours at To the Funeral D 1 Descriping Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 E.TSO Hospice Ichey 31. Date filed (Month, Day, Year) 2. Registra s Signature State 0 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ¥991214 JAMMBARY Day 8 **Physician** 12:30 MP JOSEPH PEOPLE HILL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner Center on timore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**№** M 2□F 68 VA 224-40-8823 MAR 4. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State **e**how troumatic event, the Madical Examiner near be notified at 1X Yes 2 □ No Director BALTIMORE 286-1 MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō USA Items 23a 812 REGISTER AVENUE 21239 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. AFRICAN filed within 72 hours after 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced "neturel", Year or Dates: AMERICAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PAINTER LABORER 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I is marked WARDS SARAH D. JOHN Ρ. HILL ၉ 19a. Informant's Name/Relationship (Type, Print) ROTHER IN of Health and h 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)) 4522 SPRING **AVENUE** BALTIMORE MD LEWIS & MILDRED BALL SIST LAW / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. 01-31-04 CATONSVILLE, MD **METRO** CREMATORY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WYLIE FUNERAL HOME PA 6 638 N. GILMOR STREET BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ACUTE RENAL FAILURE Friysician resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physicien Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Jo in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐ Yes 2 ☐ No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by pe INTERSTITIAL PNEUMONIA 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No ANKYLOSING SPONDYLITIS 24a. Was an autopsy performed² res 22No page 2 212 No 1 ☐ Yes of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral dir 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation in by the after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert (\mathcal{V}) D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 BOON F. LIM. 32. Registra Signature 31. Date filed (Month, Day, Year) State FEB 0 2 2004) Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland		rtment of Hea ificate of De		tal Hygiene Reg. No	ZHHIS	02598
7	Physicia	20	Decedent's Name (First, Middle, L.	ast)			A	ate of Death Aonth Da	y Year	3. Time of Death
-	/Medic	al	darry C.	Hearn	_ ~	4b. City, Town, or Loc			County of Death	5:15 AM
	Examin	er	4a. Facility Name (If not institution, g	ive street and number) ACT	٤.	0	URZ.		01	RE
	Funeral		Collection of the second	Sex 7. Age (In yrs. Ia 1 X M 2 ☐ F		If Under 1 Year If I	Under 24 Hrs. 8. D	ate of Birth Month, Day, Year)		ace (State or Foreign
П.	Director		Usual Residence of Decedent	53	Yrs.		1/2	N.3F 10.	so MAR	MANO
	ryland how		10a. State 10b. County	10c. City.	, Town or Loca	ation			1	Od. Inside City Limits
	8a-f s	Director		3906	ALTICA	1		40- 0	in a state of the control of the con	1 ☐ Yes 2 No
	with the		10e. Street and Number	Mrs. Rom A	GT 5	10f. Zip Code	7	10g. Cil	izen of What Coun	uy:
	death	Funeral	3305 Jalen Vi 11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. W	as Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Specify Sexican, Puerto Ricar	Yes or No-	14. Race - Americ Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show important: If term 27 is marked other than "astural", or items 23a or 28a-f show any injury or other traumatic event, I as Medical Examiner must be notified at once.	by Fu	1⊠ Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 250 No If Yes, Give		_ ~	pecify:	, 0.0.,	Specify:	- V
21215-0036	2 hour	ted b	15. Decedent's		16a. Decede	ent's Usual Occupation	1 , , ,	16b. K	and of Business/Inc	dustry
215	thin 7.	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k.	ind of work done durin O NOT use retired)	ig most of working			
72	iled will have the the the the the the the the the th		17. Father's Name (First, Middle, Lat	St)	LA	RKIER 18.	Mother's Name (Firs		Sumame)	cu
Maryland	id be f ental f ked of ic eve	To Be	BANDOLPH	Silver			DANK	HEAT	H	
lary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship		19b. Mailing	Address (Street and	Number or Rural Ro	ite Number, City	or Town, State, Zip	Code) AUS
	tealth tealth om 27 her tr	100		SOU SOU SOU SOU	ace of Disposi	tion (Name of	Date	3001	ocation - City or To	MA CO
altimore,	Pages nent of H int: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Contents)	☐Removal from State	metery, crema	atory or other place)	JAN-31	E	oned Hall	1 110
altin	permit. P Departme Importan any injuri once.		21. Signature of Funeral Service Lice	The state of the s		Name and Address of	Facility 2325	VORKRO	2 Timoni	um MD
<u>~</u>	Depar Impo	7 7	Pelsto	Stellet	Re	aceful Al	ternative	Funera	O & CROMO	tion Center
4			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death by one cause on each line.	. Do not enter	r the mode of dying, su	uch as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Strok	<u>e</u>					2 weeks
45	Examiner			Due to (or as a consequ	0515					3 years
	р <u>н</u>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of).			1.0- :	100	Wyears
	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):	ired I h	inuned	enuen	14 34 h	done
8760,	icate be executed physician and s the burial-transit	dlcal E		d						
89	E 0 4	ab I	IF FEMALE:							
Вох	that the death certific ed by the attending p detached for use as i	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3 □E	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
o.	t the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	a 5	Ottlet (specify)				
<u>a</u>	res that the igned by th be detache	by PI	Part II. Other significant conditions	contributing to death but not resu	lting in the und	derlying cause given in	Part I.	23e. Did tobacco	use contribute to th	
Vital Records,	v requires been sign should be							1 Yes 2	□ No 3 □ Prob	ably 4 Nonknown
Rec	e law has b je 2 si	Completed						24a. Was an autopsy performed?	prior to cor death?	osy findings available appletion of cause of
tal		0	25. Was case referred to medical			26	. Place of Death (Ch	eck only one)	1 Tes	2 No
	di di	To B	examiner? 1 □ Yes 2 No	Hospital: 1 Inpatient 2 E	ER/Outpatient	3□ DOA Other:	4 Nursing Home		6 □Other (Specify)
	ling PI		27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes	28d.	Describe how inju	ry occurred	
isic	Attending r death. ector: After by the fune	ficat	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	t be an Blace of Injury . At hor	me, farm, stre		28f. L	ocation (Street ar	nd Number or Rura	Route Number,
2	s after s Dire ed in b	Certification;	4 Homicide	building, etc. (Specify,			(City or Town, State	9 <i>)</i>	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of my know aminer: On the basis of examinati and manner stated.	wledge, death ion and/or inve	occurred at the time, o estigation, in my opinio	date and place, and c on, death occurred at	lue to the cause(s the time, date an) and manner as st d place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2		29c. License nu	mber	29d. Da	te signed (Month, I	Day, Year)
)			CYPL	- MA		056	107	0	1/30/0	4
	10		30. Name and address of person when the same of the sa	o completed cause of death (Item	23a) (Type, P	rint)	Cas Ho	SPITAL		
	Sta Regist		31. Date filed (Month, Day, Year)	0 2 200	ure	Print)				

State of Maryland / Department of Health and Mental Hygiene 200For State Registrar Certificate of Death Reg. No 2. Date of Death lent's Name (First, Middle, Last) 10A.M **Physician** /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner We 9. Birthplace (State or Foreign Country) Age (In yrs. last birthda) If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 M 2 F Months Days Hours 217-07-619 aR. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 (No olumbia Director 10g. Citizen of What Country? 10e. Street and Number 21045 To Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) t of Health and Mental Hygiene. If item 27 is marked other than 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sate, Zip Code) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department of Important: If any injury or once. Moreland Mom. Hack 1-259 **4** □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BALTI MORE, MD 21234 CHAPEL, 8500 HAY Approximate
Interval Between
Onset and/Death 23a. Part1. Enter the disease, ir on shock, or heart failure. List only mplications that caused the only on a cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (because of that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical Examiner ng physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy for Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause give win Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performs this certificate has al director, page 2 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 6 Other (Specify) Medical Certification: To 27. Manner of Death
1 Natural
2 Accident 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? After 5 Pending investigation 1 Yes 2 No filled in by the fi 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 🗌 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person wi completed cause of death (Item 23a) (Type, Print) FREILICH 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Earnest Leland Higginbotham January 19, 2004 4:00 PM M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 745 Red Cedar Road Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Apr 8, 5. Social Security Number 9. Birthplece (State or Foreign Country) Louisiana 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F 84 Director 579-16-7964 Usual Residence of Decedent the Maryland 10a. State of Mental Hygiene. marked other than "natural", or Items 23a or 28a-1 show matic event, It a Medical Examinat must be inclifted at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 745 Red Cedar Road filed within 72 hours after death by Funeral 21401 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) minister religion Pages 1 and 2 should be file timent of Health and Mental Hytent: If Item 27 is marked oth jury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Percy Odom Higginbotham Rexie Feliciana Stanton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ethne F. Higginbotham/spouse 745 Red Cedar Road Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature fineral price Licensee Nade, Lirector State Anatomy Board 655 W. Baltimore Street naul Baltimore, MD 21201

23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

MUTHS Immediate Cause (Final disease or condition resulting in death) **Physician** myelogenous eukemia /Medical Due to (or as a consequence of): Examiner MYDNIC myelo monocytic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial transit Myelodysplashi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by page 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes peed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has i autopsy performed? 1 ☐ Yes 2 Ø No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Dath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funerel Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide To the Hospitel Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number January 22,2004 Weener, Mc DSZ330 remene 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeanine Weiner MI 900Best cate Kord #30 Annapolis, MD ZIYSI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2004

Physicia /Medic		1. Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death	
AMEGIC		CAROLYN AN	N HARDEN				Month	Day Year	01.50 A	
Examin		4a. Facility Name (If not institution, gir	re street and number)		4b. City, Town,	or Location of Deat	h	4c. County of Dea		
		Sacred Her	ut Hosp	irtal	Cim	bor lan	0	Allegi		
uneral		5. Social Security Number 6. 3 219 76 1058	Gex 7. Age (// 1 □ M 2 ☐ F	n yrs. last birthday, 57 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1 JUNE 22	Year) 9. Bir	rthplace (State or Fore ountry)	
irector		Usual Residence of Decedent					JUNE ZZ	1946 MAF	RYLAND	
1		10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Lin	
Examiner must be notified at	ctor	MARYLAND ALLEGAN	Y	ECKHA	ART				1 🗌 Yes 🗶	
DE LO	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?	
dical Exeminer must	eral	17110 CARSCADEN		- in 11 C		1528	'f	U.S.		
IDEL	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \)	r in U.S. 13.	If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puerl	pecify Yes of No- o Rican, etc.)	14. Race - Am Black, Whi		
200	þ	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	WHITE	
2	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	edent's Usual Docu	pation during most of wo	tina 10	6b. Kind of Business		
Med	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	King			
7		12		F	IOMEMAKER			OWN HO	ME	
• >	Be	17. Father's Name (First, Middle, Last ROSS F					ne <i>(First, Middle, Ma</i> 'N WILLISO	,		
Detic	၉	19a. Informant's Name/Relationship		19h Maili	ing Address (Street			City or Town, State,	Zin Codo)	
or other treumetic event, the Madical		THOMAS PORTER /					, MD 2152		ZIP COOB)	
other		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Place of Dispo	osition (Name of			Oc. Location - City or	Town, State	
ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			matory or other pla		1/0/	מאר שת אוואיי		
any injury or other tr once.		21. Signature Funeral Service Lice	- 25	The second secon	CEMETERY 2. Name and Addre			KHART, MD O W. MAIN		
eny ii		Alu m	SON	> sc	WERS FUN	ERAL HOME		ROSTBURG,		
burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last	c. Due to (or as a co	,						
9	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 PNo 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date of de Month	livery Day Year	
deta	y Ph	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	inderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
ad bi	d by						1 ☐ Yes	2 □ No 3 ☑ Pr	robably 4 Unkno	
should	Completed						24a. Was an	24b. Were at	utopsy findings availa	
age	Eo	r					autopsy performe 1 Yes 20	d? death?	completion of cause : 2 No	
stor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)	10.10	2 2 140	
s certificate has birector, page 2 s	0	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier	III JE DOA		ome 5 Resident	ce 6 □Other (Spe	city)	
l direc	T T T T T T T T T T T T T T T T T T T						28d. Describe how	injury occurred		
ineral direc		1 Matural 5 Pending (Month, Day real) Injury Work? 2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be								
the tuneral direc	cati	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number City or Town, State)		
in by the funeral direc	ertificati	determined	building, etc. (S				d place, and due to the cause(s) and manner as stated. th occurred at the time, date and place, and due to the cause(s)			
etely filled in by the funeral direc	dical Certificati	4 Homicide determined	nysician: To the best of m	amination and/or in	h occurred at the ti vestigation, in my c	me, date and place opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as and place, and due	stated	
completely filled in by the funeral direct	Medical Certification:	4 Homicide determined 29a. Certifier 1 General Processing Plants (Check only 2 Medical Example)	nysician: To the best of m	amination and/or in	h occurred at the til vestigation, in my c	opinion, death occu	rred at the time, date	se(s) and manner as a and place, and due	s stated. to the cause(s)	
<u>a</u>	Medical Certificati	29a. Certifier (Check only one) 29b. Signature and title of certifier	nysician: To the best of m	amination and/or in	vestigation, in my o	opinion, death occu se number	rred at the time, date	and place, and due	s stated. to the cause(s)	

Physici	ian	1. Decedent's Name (First, Middle, Las	st)		rtificate of D		2. Date of De Month	Reg. No sath Da		3. Time of Dea
/Media	cal	17106/6		ers.	ام د	mes	Janua	1	29 2001	1
Examir	ner	4a. Fecility Name (If not institution, give	160k-	4=0:L1	4b. City, Town, or L		1:41	4c.	. County of Deat N/A	h
Funeral		5. Social Security Number 6. Si	ex 7. Age (In	yrs. last birthday		If Under 24 Hrs Hours Min		rth	9. Birtl	hplace (State or For
Director		212-84-5559 Usual Residence of Decedent	LM ZEIF	42 Yrs.				1 19		RTH CAROL
Mot		10a. State 10b. County	100	c. City, Town or L	ocation					10d. Inside City Li
in in its	ctor	MARYLAND N/A		BALTIM	IORE					1 🛚 Yes 2 🗆
Pe no	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	untry?
d other than "natural", or items 23a or 28e-1 show event. the Medical Examiner must be notified at	Funerai	2822 POTEE STREE	ET 12. Was Decedent Ever	in II S 13	21225 Was Decedent of Hisp	nanio Osigina (6	Specify Vec or No		.S.A. 14. Race - Amer	doen Indian
in the second	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 212 No	10.0.	If Yes, specify Cuban,	Mexican, Puer	to Rican, etc.)	,-	Black, White	
Erai.	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:			Specify: BLA	ACK
nat.	Completed	15. Decedent's Ed (Specify only highest gra-	ducation de completed)	(Give	edent's Usual Occupation be kind of work done dur DO NOT use retired)	on ring most of wo	orking	16b. Ki	ind of Business/l	Industry
Than M	d Ho	Elementary/Secondary (0-12)	College (1-4or 5+)		SEKEEPING			NUF	RSING HO	MF:
rked other tic event.	BeC	17. Father's Name (First, Middle, Last)		1100		8. Mother's Na	me (First, Middle,			
	To E	FRANCIS RUFUS IME	S			ELIZAE	BETH STRI	[NGF]	IELD	
item 27 is marke other treumatic		19a. Informant's Name/Relationship (7 RONNY LEF	Type, Print)	19b. Mail	ing Address (Street and	d Number or R	ural Route Numbe	er, City o	r Town, State, Z	ip Code)
item 27 other t		Ponald L. Sanders/ 20a, Method of Disposition		2822 Ob. Place of Disp	Potee St.	, Balti	more,Mar			
-		1 🕅 Burial 2 □ Cremation 3 □	Removal from State	cemetery, cre	matory or other place)	i			ocation - City or T	
Important: I any injury o once.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			ORIAL PARK 2. Name and Address		4-04	BALT	TIMORE,	MARYLAND
ang Sub	10.7	Ekanles, H	Lowell	W	2. Name and Address ILLIAM C BI	ROWN CO	MMUNITY	FUNE	ERAL HOM	E P.A.
edical	97	23a. Part1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the cone cause on each line. a	death. Do not en	206 W NORTH	H AVENU such as cardia	E		tion	Onset and Deat
edical miner	i Examiner	Immediate Cause (Final disease or condition	a. Dissem	death. Do not en	206 W NORT!	H AVENU such as cardia	E		tion	Onset and Deat
hysician and the burial-transit the burial-transit	Cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a cord). Due to (or as a cord). Due to (or as a cord). Due to (or as a cord).	death. Do not en a sequence of):	ter the mode of dying,	H AVENU such as cardia	E	rrest,	tion	Interval Between
by the attending physician and ached for use as the burial-transit and ached for use and ached for use ached for use as the burial-transit and ached for use a	Cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor Due to (or as a cor Due to (or as a cor C. Due to (or as a cor d.	death. Do not en sequence of): sequence of): egnancy Fetal death 35	206 W NORT!	H AVENU such as cardia	E	rrest,	23d. Date of delive Month	Interval Between Conset and Death
gned by the attending physician and Solor use as the burial-transit Solor use Solor us	Physician/Medicai	Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor d. 23c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	death. Do not en sequence of): sequence of): sequence of): egnancy Fetal death 35 of death 55 of de	lter the mode of dying,	H AVENU	c or respiratory and COCCA	rrest,	Month se contribute to	Interval Betwee Onset and Death Conset a
been signed by the attending physician and my particular be detached for use as the burial-transit of particular be detached for use as the burial-transit of particular between the particular between the particular burial-transit of particular buri	Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions on Pressure of the past 12 months?	Due to (or as a cor b. Due to (or as a cor c. Due to (or as a cor d. 23c. If yes, outcome of pre 1 Live birth 2 1 Pregnant at time 9 Unknown	death. Do not en sequence of): sequence of): sequence of): egnancy Fetal death 35 of death 55 of de	□Ectopic pregnancy □ Other (specify) □	in Part I.	23e. Did to 1 Yes	pbacco u (es 2[an sy med? 2]	Month se contribute to to to to to to to to to to to to to	rery Day Year the cause of death bably 4 Sunkni
certificate has been signed by the attending physician and UDB rector, page 2 should be detached for use as the burial-transit IDB rector.	o Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions cause.	Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) d. 23c. If yes, outcome of predictive birth 2 1 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	death. Do not en a sequence of): sequence of): sequence of): egnancy Fetal death of death of death of death of the sequence	□Ectopic pregnancy □ Other (specify) □ Inderlying cause given	in Part I.	23e. Did to 1 Yes ath (Check only on	pbacco u (es 2[an isy med? 2] Nio	Month se contribute to to to to to to to to to to to to to	rery Day Year the cause of death bably 4 Sunkni opsy findings avail ompletion of cause
This certificate has been signed by the attending physician and this certificate has been signed by the attending physician and the buriar-transit of polymers.	To Be Completed by Physician/Medical	Sequentially list conditions are any leading in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions on the cause of the ca	Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) d. 23c. If yes, outcome of predictive birth 2 1 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	death. Do not en sequence of): sequence of): sequence of): sequence of): tresulting in the uncompared to the sequence of t	□Ectopic pregnancy □ Other (specify) Inderlying cause given in 3□ DOA Other:	in Part I.	23e. Did to 1 Yes	pbacco u /es 2[an ssy rmed? 2] No	Month se contribute to to to to to to to to to to to to to	rery Day Year the cause of death bably 4 Sunkn opsy findings avail ompletion of cause
his certificate has been signed by the attending physician and Upper and Upper Should be detached for use as the burial-transit Upper Interest To Be Completed by Physician/Medical	Sequentially list conditions resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) d. 23c. If yes, outcome of prediction of the cord of the cord) 4 Pregnant at time 9 Unknown ontributing to death but not contributing to death but not cont	death. Do not en sequence of): sequence of): sequence of): sequence of): tresulting in the uncompared to the sequence of t	The results of the re	in Part I.	23e. Did to 1 Yes 24a. Was autop perfor	pbacco u /es 2[an ssy rmed? 2] No	Month se contribute to to to to to to to to to to to to to	rery Day Year the cause of death bably 4 Sunkni opsy findings avail ompletion of cause	
Director: After this certificate has been signed by the attending physician and Director. After this certificate has been signed by the funeral director, page 2 should be detached for use as the buriat-transit Director.	To Be Completed by Physician/Medical	Sequentially list conditions or sulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yes 9 Unknown Part II. Other significant conditions conditions or summer? 25. Was case referred to medical examiner? 1 Yes 2 Yes 9 Ye	Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) d. 23c. If yes, outcome of prediction of the cord of the cord) 4 Pregnant at time 9 Unknown ontributing to death but not contributing to death but not cont	death. Do not en insequence of): Isoquence of	□Ectopic pregnancy □Other (specify) □Inderlying cause given Other (specify) Other: 28c. Injury at Work? M 1 □ Yes	in Part I.	23e. Did to 1 Yes ath /Check only on 28d. Describe h	pbacco u /es 2 [an ssy med? 2] No ne) dence 6 forest and	Month se contribute to to to to to to to to to to to to to	rery Day Year the cause of death bably 4 Sunkni opsy findings avail ompletion of cause
Director: After this certificate has been signed by the attending physician and Director. After this certificate has been signed by the funeral director, page 2 should be detached for use as the buriat-transit Director.	Certification: To Be Completed by Physician/Medical	Sequentially list conditions or any, leading in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions or Presulting in death 1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No Yes 2 Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) d. 23c. If yes, outcome of present at time and pregnant at time and present at time at	death. Do not en sequence of): sequence of): sequence of): egnancy Fetal death of	Ectopic pregnancy Other (specify) Inderlying cause given Other 28c. Injury at Work? M 1 Yes Ye	in Part I.	23e. Did to 1 Yes ath /Check only or 28d. Describe h	pbacco u (es 2 [an isy med? 2 [bence 6 now injury fireet anom, State)	Month se contribute to No 3 Pro 24b. Were autorized to content or cont	rery Day Year the cause of death' bably 4 Synkhologopsy findings availability of cause 2 100 100 100 100 100 100 100 100 100 1	
Director: After this certificate has been signed by the attending physician and Director, page 2 should be detached for use as the burial-transit Director.	To Be Completed by Physician/Medical	Sequentially list conditions or any, leading to immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of the best of my yesician: To the best of my nimer: On the basis of exam and manner stated.	death. Do not en sequence of): sequence of): sequence of): egnancy Fetal death of	Ectopic pregnancy Other (specify) Inderlying cause given Other 28c. Injury at Work? M 1 Yes Ye	in Part I. 6. Place of Dead 4 □ Nursing Interpretate 5 2 □ No date and place ion, death occurrence.	23e. Did to 1 Yes ath (Check only or 28d. Describe h 28f. Location (S City or Tow	pbacco u (/es 2 [an sy med? 2) No fence 6 fow injury Circet and Circet and Circet and Circet and Circet and Circet and Circet and Circet and Circet and Circet and	Month se contribute to No 3 Pro 24b. Were autorized to content or cont	rery Year The cause of death bably 4 Synkhol copsy findings avails completion of cause 2 100 al Route Number, stated. o the cause(s)
Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of the cause on each line). Due to (or as a condition of the cause of	death. Do not en sequence of): sequence of): sequence of): egnancy Fetal death of	Ectopic pregnancy Other (specify) Inderlying cause given 28c. Injury at Work? M 1 Yes reet, factory, office 29c. License ni	in Part I. 6. Place of Dead 4 □ Nursing Interpretate 5 2 □ No date and place ion, death occurrence.	23e. Did to 1 Yes ath /Check only or 28d. Describe h 28f. Location (S City or Tow	pbacco u (es 2 [an sy med? 2] No ne) dence 6 now injury Street and nown, State) cause(s) date and	Month se contribute to a large of the prior to or death? 1 Yes Cocurred and manner as splace, and due to a signed (Month,	rery Year The cause of death bably 4 Synkhol copsy findings avails completion of cause 2 100 al Route Number, stated. o the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND ITEM #20b PER FH G828 2/02/04 Certificate of Death Reg. No. C. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner A 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) ff Under 1 Year Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** Months Hours Min. 10 M XOF Days Director 07-20 6000 5,192 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Itams 23a or 28a-f ahow the Medical Exactiner must be notified at 1/2 Yes 2 □ No by Funeral Director Baltomire 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 20 Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Year or Dates natural Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) Colfege (1-4or 5+) 2001al WORK WORKER nt of Health and Mental Hyg if Item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aliazen BRANNON Dmus 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bultimere BudgER GotE HudRES JACKSON 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 tmant of 1 GARRISON TURESTOCIMIACO 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) per nit. Page Decentment of Important: If any injury or one. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 132 Funeral Home DIASMERG MD JINE Satura 1129 CAROLINE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medicai Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetef death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? II. Other significant condition contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ρ 14213 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page 2 certificate To the Hospital or Attending Phyaician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 2 ER/Outpatient 3□ DOA 2 this funeral 27. Manner of Death a of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Accident 6 ☐ Could not be 3 T Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year)

FEB 0 2 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year lana 5:15 pm January 27, 2004 ocation of Death 4c. County of Death /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Baltimore Point Norsing Center

6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 3/00 If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□ M 2**□** F Months Days 215-86-9594 Director January 10, 1971 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Mn 1 1 Yes 2 □ No Funeral Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 2525 12. Was Decedent Ever in U.S. Armed Forces? 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 0. 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: B lack "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Fresh Fields 17. Father's Name (First, Middle, Lest) Be 18. Mother's Name (First, Middle, Maiden Surname) Important: if item 27 is marked any Injury or other traumatic evonce. Milton L. Jessup Ja ဥ Patricia A. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, cremetory or other place)

Date

Date

Date

Document City or Town, State La Sharn Williams/Sister
20a. Method of Disposition 20b. 1 ■ Burial 2 □ Cremation 3 □ Removal from State Lowen Park Cemetery 2/3/04 Baltimore, NO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
Hari P. Close Funeral Service, P. A.
709 Tessier St., Baltmore MD ZIZO 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore MD ZIZOI **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer Examiner Due to (or as a consequence of) Physiclan/Medical Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of) ate has been signed by the a page 2 should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Ś Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

altimore, Maryland 21215-0020

P.O.

of Vital Records,

Division

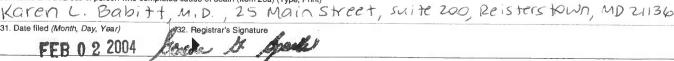
State Registrar

31. Date filed (Month, Day, Year)

Drawn L. Baltt, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29d. Date signed (Month, Day, Year)

January 27, 2004

00058676

			For State Registrar	State o	f Marylan		irtment of tificate of		nd Mental	Hygien Reg. N	U	04	02605
	Physicia		Decedent's Name (First, Middle, Catherine	Last)			Jones		2. Date of Month		2004	'ear	3. Time of Death 10:40a M
	/Medic Examin		4a. Fecility Name (If not institution, Future Care N.		mber)		4b. City, Town,	or Location of			c. County of		e
	Funeral Director		243-07-0989	6. Sex 1 □ M 2 💢 F	7. Age (In yrs.) 99	ast birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. 8. Date of (Mont) 12	of Birth h, Day, Yea 25	v) 04		ece (State or Foreign ry) C
	death with the Maryland ms 23e or 28e-f show from the notified at	ctor	Usuel Residence of Decedent 10a. State 10b. County MD Balt:	imore		y, Town or Lo	cation 3 Mills	3,					od. Inside City Limits 1 ☐ Yes 2火火o
	ath with the 23a or 28	Funerai Director	10e. Street and Number 9200 Applefor		e #240			21117	gin? (Specify Yes		U.S.	Α	
5-0036	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show sidical Examinat matal be notified at	by	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ◯ Widowed 4 □ Divorced	Armed Fo	orces?	1	f Yes, specify Cu	iban, Mexican,	Puerto Rican, etc	i.)		White, e	
U-C121		Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most red)	of working		Kind of Busi		
land Z	be filed tal Hygi of other event, I	To Be Co	6th grade 17. Father's Name (First, Middle, L Edward Van				mescro		r's Name (First, M				known
e, mary	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationsh Dennis E. Dowl 20a. Method of Disposition			9200			Circle,	#24		ring	s Mill, M
altimore,	Page nent o ant: If ury or		XXBurial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service I	ecify)	State C	_{emetery, crer} Ltimor	natory or other p	onal	2/3/04	Ва	ltimo	re,	
n n	permit. Departe Importe any inj		23a. Part 1. Enter the disease or shock, or heart failure List	complications that complications	aused the death		March F.		t 43	00 Wal	bash A	ve.	Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	_ a	(or as a conseq	phia							Onset and Death Ohe WEIK
	ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Diseases a munitimated events resulting in death) Last	с.	(or as a conseq							Ī	
58760,	ficate be executed physician and s the burial-transit	dicai	resulting in Geattly Last	d.	(or as a conseq	uence ot):							
.O. Box (The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ Uo 9 ☐ Unknown	1 Live	tcome of pregna pirth 2 Feta nant at time of d own	Ideath 3	Ectopic pregnar Other (specify)				23d. Date Monti		ry Day Year
1	w requires that been signed b should be deta	by	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	nderlying cause	given in Part I.	23e.				e cause of death?
il Records,		Completed							24a.	Was an autopsy performed?	pri de	ere autop or to con ath? Yes	osy findings available inpletion of cause of
of Vital	y Physician: The sertificate oral director, pag	n: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 25 No 27. Manner of Death	28a. Date	Inpatient 2 of Injury	28b. Time o	f 28c. in	Other: 4 Nu	of Death (Check rsing Home 5 28d. Desc	Residence	6 Other)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifical completely filled in by the funeral director.	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide Homicide (Month, Day Year) Injury Work? 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									Route Number,	
	To the Hospital or At within 24 hours after d To the Funaral Direct completely filled in by	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the Examiner: On the band man	e best of my kno pasis of examina nner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in m	time, date and y opinion, deat	d place, and due to th occurred at the	o the cause time, date a	(s) and manr and place, an	ner as sta d due to	ated. the cause(s)
l.	To t To t	2	29b. Signalure and title of certifie	10 MB)		29c. Lice	onse number	30	29d. (Date signed	Month, E	2004
1	2		30. Name and address of person 3 3 3 3 1 31. Date filed (Month, Day, Year)	Calrer 1	se of death (Iter	n 23a) (Type,	660	Ba/ti	here 14	1.2	12/8		
	Sta Regist	ate rar	FE	B 0 2 200	Togistial applyfic	som Si	A Space						

			- FOI	_	/ Department of Health and I	Mental Hygie Reg.	_
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) A. Facility Name (If not institution, give si	ANE Key	4b. City, Town, or Location of Deat	January	Day Year 3. Time of Death Ac. County of Death
	Funeral Director	ier	Mayland Ger 5. Social Security Number 6. Sex	M 2) Age (In yrs. las	ital Baltimore	8. Date of Birth Month, Day, Ye	A Ristholace (State or Foreign
^	e Maryland Sa-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Wartyloro	BAL	Town or Location Hope or		10d. Inside City Limits
5	th with the Mi 23e or 28e-f	Funeral Director	10e. Street and Number 2871 EDGEC	OMBE CIRCLE N. AP	T E. 10f. Zip Code	10g.	Citizen of What Country?
036	n 72 hours after death with the Maryla "natural", or Items 23e or 28s-f eho suksal Evantinser nast be rollflied at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
3		Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of worlife. DO NOT use retired) HOUSE KEEP ING	rking	Wate Insurate
aryland 2	2 should be filed and Mental Hygi is marked other aumatic event, I	To Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maid	den Sumame)
<u></u>	ges 1 and 2 should be filed within tof Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Merenethan or other traumatic event, the Merenethan traumatic event, the Merenethan traumatic event, the Merenethan traumatic event, the Merenethan traumatic event, the Merenethan traumatic event, the Merenethan traumatic event, the Merenethan traumatic event, the Merenethan traumatic event, the Merenethan traumatic event, the Merenethan traumatic events are the merenethan traumatic events and the Merenethan traumatic events are the Meren		19a. Informant's Name/Relationship (Typ. Name/Relationship (Typ. 1 Burial 28 Gremation 3 Re	/168 E 20b. Pla	19b. Mailing Address (Street and Number or Ric 205 Desired Rose Bla- ce of Disposition (Name of netery, crematory or other place)	Atinore,	Mary / Horses 3/2/1
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 20058.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22. Name and Address of Facility Ch 52 YO PEL TOSKOW K	A TAIRN - K	arris Fines Gene
	Physician /Medical		23a Part : Enter the disease, or complic shock, or year failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Do not enter the mode of dying, such as cardiad	or respiratory arrest,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	enia		
8760,	cate be executed obysician and the burial-transit	dicai Examiner	Causs (Disease of Injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):		
.O. Box 68	The law requires that the death certifics te has been signed by the attending proge 2 should be detached for use as it	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	eath 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
4	w requires that to be the control of	ted by Ph	Part II. Other significant conditions con	tributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Minknown
al Reco		e Comple	25. Was case referred to medical		OC Plans of Dec	24a. Was an autopsy performed 1 Yes 2 wath (Check only one)	
Division of Vital Records,	ng Phys fter this ineral dii	ToB	examiner? 1 Yes 2 No H. 27. Manner of Death 1 Matural 5 Pending		Other		e 6 Other (Specify)
Divisio	2 th 2 c	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, late)
	he Hospital n 24 hours a he Funeral I pletely filled	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowl er: On the basis of examinatio and manner stated.	edge, death occurred at the time, date and place in and/or investigation, in my opinion, death occu	, and due to the cause irred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complei	Σ	29b. Signature and title of certifier P. (Chal.)	6,	29c. License number	29d.	Date signed (Month, Day, Year)
_	\		Parisa Kha	mpleted cause of death (Item 2	(3a) (Type, Print) Nav Nand (serrera	1 Hospital
*23	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 2 2004	32. Registrar's Signatu	Seed !		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				For State Registrar	State of Ma	aryland		rtificate of		лептат пу	Reg. No	200L	02607	
		Physicia	an	1. Decedent's Name (First, Middle,	2. Date of Death Month Day Year 3. Time of Death									
		/Medic	al	JAMES FR. 4a. Facility Name (If not institution, g	Januar		2004 C. County of Death	20:15p ^M						
		Examin	er	HARFORD MEMORIA					r Location of Death DE GRACE			HARFORD	CO	
		Funeral			Sex 7. Ag	je (in yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year	9. Birth	place (State or Foreign	
		Director		213-38-7276 Usual Residence of Decedent	FEDW 2017	62	Yrs.			AUGUST 11 1941 MARYLAND				
		ow ow		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits	
		th the Marylan or 28a-f show	ctor	MARYLAND HAR	FORD CO			ABERDEEN					1 ☐ Yes 2 💆 No	
~		ith the Maryla or 28a-f show	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	ntry?	
~		eath w		200 PERRYWOOD C	12 Was Decedent	Ever in U.S	S. 13.	2100 Was Decedent of H		ecify Yes or No		J.S.A. 14. Race - Ameri	can Indian,	
9	′0	r Item	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces?	1			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White,		
2	93	raf, o	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		i	1 ☐ Yes 2 ☐XNo	Spеспу:			Specify: BLA		
5.5	215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If the marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Markleal Examinations to notified a	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of world)	king	16b. l	Kind of Business/In	dustry	
20	212	withir	ошо	Elementary/Secondary (0.12) 9th grade	College (1-4or !	5+)	unkn		-/		l N	I/A		
10		be filed tal Hygid d other event, I	Bec	17. Father's Name (First, Middle, La	ist)	,			18. Mother's Nam	e (First, Middle	, Maide	n Sumame)		
	ylaı	ould b Menta Marked Marked	10	WILLIAM W KEATI						E KEAT				
ナ	Maryland	12 shoth and 7 is m.		19a. Informant's Name/Relationship				•	and Number or Rui		-		o Code)	
0		1 and Healt lem 2		Crystal Keating 20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of		Date	20c. l	ocation - City or T	own, State	
8	ē	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State cify)			matory or other plac EMATORY	02-0	2-04	BAI	LTIMORE,	MARYLAND	
13	Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Puneral Service Li	Pawel	e	W 3	2. Name and Addre M C BROWN 21 S PHII	ss of Facility N COMMUNI LADELPHIA	TY FUNE	RAL ABEF	HOME-HAR	FORD, P.A. 21001	
			$\overline{}$	23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused by one cause omeach li	d the death							Approximate Interval Between	
		Fnysician /Medical Examiner	0.1	Immediate Cause (Final disease or condition										
				resulting in death) Due to (or as a consequence of):										
			e e	Sequentially list conditions, The following to an important the following to an important the following to the following the fol										
		outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
	ő,	icate be executed physician and s the burial-transit	Ex	resulting in death) Last	Due to (or as	a consequ	ence of):							
	68760,	ficate be physicials the bur	edical		d									
	Вох 6	- CD -		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			35				23d. Date of deliv	ery	
3	O. B.	that the death cer ed by the attendir detached for use	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant a 9□Unknown			⊒Ectopic pregnanc; ⊒ Other (specify) _	<u> </u>			Month	Day Year	
X	ds, P.	The law requires that the death certi tte has been signed by the attending page 2 should be detached for use a	Completed by Physician/M	Part II. Other significant condition	23e. Did tobacco use contribute to			he cause of death?						
2	_ <u>5</u>	w requires been sign should be	iete	lumerten	No.		***			24a. Was			opsy findings available	
)	of Vital Rec	ysician: is certifica director. p	dmo	Swangamullaca							autopsy performed? 1 ☐ Yes 2 ☐ No		prior to completion of cause of death? 1 Yes 2 No	
~			BeC	25. Was case referred to medical 26. Place of Death (Check only one)										
\gtrsim			ပို	1 □ Yes 2 No	Hospital: Inpati			nt 3 DOA		ome 5 ☐ Res 28d. Describe		6 ☐Other (Speci	(y)	
7		tending Ph Jeath. tor: After th the funeral	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		ay Year)	28b. Time of Injury	Wo		200. Describe	now mj	ary occurred		
3	Division	l or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of In	jury - At ho tc. (Specify	me, farm, st	reet, factory, office		28f. Location City or To		und Number or Rur te)	al Route Number,	
3	0	pita ours seral		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
	X	To the Hos within 24 h To the Fur completely	Medical	one)	xaminer: On the basis of and manner si		iion and/or ir			rred at the time				
	\	To the within 2 To the complete	2	29b. Signature and title of certifier	1.1/1			29c. Licens	737(L	-	Z30. D	ate signed (Month,	19 700CL	
	•	3		30. Name and address of person w	tho completed cause of	death (Item	23a) (Type	Print)	1,107	0	المل	in of		
				1) Walnu	& Lane,	Ab	erde	en, M	anxan	1				
		Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32 Regist	rar's Signa	ture	1946	0					

		-	For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 026									02608		
	ysicia		Decedent's Name (First, Middle	, Last) Ruth	C1	evelan	d K	ifer			2. Date of Dea Month Januar	Day	Yeer	3. Time of Death	
	Aedic amin		4a. Facility Name (If not institution,	give street and numb	er)		4b. City, 1	Town, or	Location of	of Death	o and a	4c. County		2:34 P	
			Johns Hopkins Ba	ayview Medi	view Medical Ctr.			Baltimore Ci			Lty	N/A			
Fun	eral		5. Social Security Number	6. Sex 7. 1 ☐ M 2X F	Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	, Year)	9. Birthp	lace (State or Foreign	
Dire	ctor		218-01-1810	ILIM ZEJF	83	Yrs.					June 18	,1920		ry1and	
and	**		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				·	10d. Insid			
Mary -1 sh	The d	ţo	Maryland Ba	1timore		г				Dunc	1 n 1 le		1 ☐ Yes 2√g		
n the	Insti	lrec	10e. Street and Number	al CIMOLE	.IIIOI C			Code		Dune		10g. Citizen of V	What Cour	ntry?	
th wit	4	ai D	1734 Bayard Avenue							222		Unite	d St	ates	
5-0036 72 hours after death with the Maryland natural; or Itame 23a or 28e-f show	MEE	Funeral Director	11. Marital Status	12. Was Decede Armed Force	ent Ever in U	rer in U.S. 13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto					ecify Yes or No- Rican, etc.)	14. Rac	14. Race - American Indian, Black, White, etc.		
36 safte or It	Harrie Harris	by Fu	1 Never Married (1 Yes, Give 1 ∨ Y					☐ Yes 2[x]No Specify:					<i>i</i> :		
21215-0036 3d within 72 hours afi giene. er than "natural", or	A Ex	q pa	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation								16b. Kind of Bu		White		
15. in 72	Andic	Completed	(Specify only highes	t grade completed)		(Give	kind of wor DO NOT us	k done d	uring mos	t of worki	ing	TOD. KING OF DE	23116337111	dustry	
of filed within all Hygiene.	Tie	E O	Elementary/Secondary (0-12) 11 Years	College (1-4	or 5+)		Home	emak	er			0	wn Ho	ome	
be filed trial Hyginal dother	vent,	Bec	17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Name	(First, Middle,				
arylai should b nd Menta	atic •	10	Frank McNew							Ruth	Hooven				
Maryland id 2 should be file tth and Mental Hy 27 is marked oth	E P		19a. Informant's Name/Relationsh		ısband		-				il Route Numbe				
	hert		Mr. Howell F. k	lifer, Sr.	20h (34 Bay	-	Ave.		ltimore			21222	
Mor Pages 1 Tent of F	or of		20a. Method of Disposition 1 Burial 2 □ Cremation		ate C	emetery, crei	matory or ot	ther place			1	20c. Location -	•		
	injury 9.		* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		Ho	lly Hi	LL Mer 2. Name and				2004	Middle	Rive	er, MD	
Balt permit. Departr Imports	eny ii		Zi. Signaturojor i unistan sorvisto i				Duda-I	Ruck	Fune	ra1	Home of				
	n (1)	+	23a: Part1. Enter the disease or shock, or heart failure. List (omplications that cau	sed the deat	h. Do not ent	7922 Ver the mode	Vise e of dying	Ave , such as	cardiac o	ndalk, or respiratory ari	Mary Land est,	a 21	222 Approximate Interval Between	
Box 68760, death certificate be executed Example and eathending physicien and	lical iner	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to or Due to for C. Due to (or Due to (or	a consequence as a cons	juence of):	by it	AG.	HUS	W	-Dife				
Box 6 death certific e attending p	or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outco 1	n 2 ∏ Feta tat time of d	Ideath 3	Ectopic pre					23d. Dat Mor	e of delive	ory Day Year	
ords, P.O requires that the	pe pe	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
I Rec The law ate has t	page 2	Completed									24a. Was a autop: perfor 1 🗆 Yes	med?/	prior to con leath?	psy findings available inpletion of cause of	
of Vital F Physician: Th this certificate	director,	Be	examiner? Hospital:								ath (Check only one)				
<u>~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ </u>	raldi	2	27. Manner eath 28a. Date of Injury 28b. Time of 28c. Injury at								Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
Vision Attending r death.	fune	tlor	1 atural 5 Pending 2 Accident investig	(Month,	Day Year)	Year) Injury		Work? M 1 ☐ Yes				,,			
Division al or Attending s after death. Il Director: Afte	od in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th	pletely fills	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1									the cause(s)				
To t with. To t	Eoo	Σ	29b. Signature and two of distribution 29d. Date 29b. Signature and two of distribution 29d. Date 29b. Signature and two of distributions 29d. Date 29b. Signature and two of distributions 29d. Date 29b. Signature and two of distributions 29d. Date 29b. Signature and two of distributions 29d. Date 29b. Signature and two of distributions 29d. Date 29b. Signature and two of distributions 29d. Date 29b. Signature and two of distributions 29d. Date 29b. Signature and two of distributions 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29b. Signature 29d. Date 29d							9d. Date signed	Date signed (Month, Day, Year)				
5			30. Name and a dress of person v							12	0000000		v	1	
	0.5		Kuimarce Kashi 31. Date filed (Month, Day, Year)		29 Dun istrar's Sign	dalk A	ve.	Dun	dalk,	, Mar	yland	21222			
Re	Sta gistra		Sale med (Month, Day, 1941)	EER 0 2 201		36 . m	20	Land	May 8						

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of He			ne No. 2004	02609
4.	nto o	ş*	1. Decedent's Name (First, Middle, Las	it)				2. Date of Death	Day Year	3. Time of Death
1	Physicia /Medic	-	Ruth Kenney					Tanuar	25, 2004	6:23 A M
	Examin	3.00	4a. Facility Name (If not institution, give			4b. City, Town, or L	ocation of Death		4c. County of Death	
152			Doctor's Hospita		a (la usa la at histhetau)	Lanham If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Prince Geo	
	Funeral		5. Social Security Number 6. Social Security Number 1	ox / Ag □ M 2 □ XF	e (In yrs. last birthday) 92 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Jan, 31, 1	ear) Sump Cour Oll Wire	place (State or Foreign htry) ginia
dec	Director	}	Usual Residence of Decedent		,,,			Jané 21 è 1	. JII VII§	SIMA
	yland now	Ì	10a. State 10b. County		10c. City, Town or Le	ocation			1	0d. Inside City Limits
	ith the Marylan or 28a-f show	Funeral Director	MD Prince Ge	eorge's	Capito1	Heights 10f. Zip Code		10g.	. Citizen of What Cour	1 ☑ Yes 2 ☐ No ntry?
	3e or		1207 Drum Avenue	2		20743			115	SA
	death ms 2:	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spec	ify Yes or No-	14. Race - Americ	an Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Madical Examinar must be natified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	40	1 ☐ Yes 2 ② No		ican, etc.)	Specify: B1a	
ŏ	2 hou	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occupat	ion	161	b. Kind of Business/In	dustry
215	hin 7.	Completed	(Specify only highest gra	College (1-4or 5	ife.	kind of work done du DO NOT use retired)		g		
21	ad wit	5	4	10.00	Laun	dry Presse			Private	
pu	ould be filed with Mental Hygiene. arked other then atic event, the M	Be	17. Father's Name (First, Middle, Last)			1	18. Mother's Name Eurola V		den Sumame)	
yla	should I	၉	Jimmy Banks							
Maryland	2 sho n and fs m		19a. Informant's Name/Relationship (ity or Town, State, Zip	
	1 and Health em 27 ither tr		Ann Scottland - 20a. Method of Disposition	Daugnter	20b. Place of Disp			-	c. Location - City or To	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr		1 A Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		Ft. Lin	coln Cemet	ery 1/31,	/04 I	Brentwood,	
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Licer	Mille		2. Name and Address 3831 Georg			neral Home ington, DC	20011
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not en	ter the mode of dying.	, such as cardiac or	respiratory arrest.		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Armit	e sube	molocas	local-V	Lyocalia	Lindante	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	- 11	D 01 00 - 1	,	114/00/21	
	Examiner		Ponumiestu liet ennotitone	Diabe	hes Wei	litro				
	outed id ansit	aminer	Eaguer Hally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunat-transit	cai Examine	resulting in death) Last	Due to (or as	a consequence of):					
99	ntifica ng ph as th	Medi	IF FEMALE:						- /-	-
. Box	The law requires that the death certifica ate has been signed by the attending phrage 2 should be detached for use as the	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 Live birth 4 Pregnant al 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ory Day Year
P.0	at the by th	hys	9 🗆 Unknown						L.	
	as thi	by F	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	underlying cause giver	n in Part I.	1	co use contribute to the	
ord	equir en si ould l	ted						1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Onknown
Records,	law re as be 2 shi	pie						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
		Com						performed 1 Yes 2 ∑	d? death?	*
Vital	yaician: The law is certificate has director, page 2 s	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
of V	Phyaid this of	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpalie			4 Industrig From		e 6 Other (Specific	y)
ion	Attending Phyaician: r death. ector: After this certific by the funeral director,	Certification:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year) 28b. Time of Injury	Work?	at ? es 2 \(\text{No} \)	3d. Describe how	inju ry occurred	
Division	after de Directo d in by th	ertific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of in	ury - At home, farm, st c. (Specify)	reet, factory, office	21	Bf. Location (Stree City or Town, S	t and Number or Rura (tate)	i Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best niner: On the basis o and manner st	of my knowledge, dea f examination and/or ir ated.	th occurred at the time nvestigation, in my opi	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner as si and place, and due to	lated. the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month,	Day, Year)
	- 5 - 0) The man	~		MO D.	53718	1	125/04	
	h		30. Name and address of person who	completed cause of a	leath (Item 23a) (Type				1	
	5		Thomas Hanss	Sug /		0 11	mhan,	maryla	nd 20-	706
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature		1	J		
	Registr		EED 0 9 200	14 Real	1 K	auth !				
DH	IMH 17 Rev 1/2	001	TED V & LUC	Jacob Com	- July					
					ORIGIN	!AL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #30 PER DVR G828 2/02/04/Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kendall Month Year **Physician** her :00 Jan 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Assisted Living BRIGHTVIEW ma. Gatonsville 7. Age (In'yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Min. 214-38-0386 1 □ M 2 KF Yrs. Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28a-f show the Medical Exeminer has the putitied at Baltimore 1 ☐ Yes 2 No Md tonsu Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 228 2 filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 2 X No 1 🗌 Yes þ Specify: Coucasean 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symame) Be . Pages 1 and 2 should be fit timent of Health and Mental H tent: If item 27 is marked others. ma 19a. Informant's Na e/Relationship ype, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Lendale Son New bus 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crtent: N Anatomy Board ' 4 Donation 5 Other (Specify) ninny Ballinon permit.
Deportri Importe any nju 2. Name and Address of Facility Andloney 21. Signature of Funeral Service Licensee RM Mel 2/20, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Enter the disease, or complications that or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive /Medical as a consequence of): **Examiner** torle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial physician Physician/Medical the detached for use as IF FEMALE NIA 23c. If yes, outcome of pregnancy /
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery N/A 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2 No P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ page 2 should be 2 No 1 Yes 3 Probably 4 Unknown Be Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No 2 X No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 5 Residence 6 Nother Specify SISTED hurne Other: 1 ☐ Yes 2 💢 No Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at WAA
Work?
1 □ Yes 2 □ No 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation NIA NIA the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar

2

(Check only one)

GLOR IA

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

en

MB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

BRIGHTVIEW ASSISTED LIVING CATONSVILLE, MD.

766 (Md

29d. Date signed (Month, Day, Year)

			1 State	State of Marylan		artment of H			2111	14 02611
			Registrar 1. Decedent's Name (First, Middle, Last)		00	tinicate of L	Jean	2. Date of Dea	ith	3. Time of Death
	Physicia	an	PATRICK	1		VELLV		Month	0.0	ear 12:08 PM
	/Medic Examin		4a. Fecility Name (If not institution, give sti	reet and number)		4b. City, Town, or	Location of Death	1	4c. County of	
	Examin	er	Sina Hospital o	of Baltino	u	Boch:	more			N/A
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9	Birthplace (State or Foreign Country)
Ð	Director		214-50-4375 ¹ X	M 2□F	7 Yrs.	Months Days	riodis Willi.	8. Date of Birth (Month, Day APR. 10	,1946	MD
	pu 🖈		Usuel Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	ocation				10d. Inside City Limits
	daryis	5	MD BALTI			HERVILLE				1 ☐ Yes 2 ☐ No
	the A 28a-	Director	10e. Street and Number	TORL	LUII	10f. Zip Code			10g. Citizen of Wh	at Country?
	3a or		11306 WOODLAND DR	IVF			21093			U.S.A.
	ours after death with the Marylan al', or Items 23a or 28a-f show Examinat must be rictified at	Funeral		2. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Race -	American Indian, White, etc.
9	after or Ite	F	1 ☐ Never Married 2 💢 Married	1 Yes 2 No		1 ☐ Yes 2 ☑ No	Specify:	o rincari, etc.)	Specify:	
93	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show coloni Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		^				WHITE
5	in 72 ho 1 "natur Redical	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	king	16b. Kind of Busin	ness/Industry
12	filed within Hygiene. Ither than " ant, the Mes	Ę	Elementary/Secondary (0-12) 5+	College (1-4or 5+)		TEMS ANAL'			U.S. GO	VERNMENT
0		Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Sumame)	
Maryland 212/15-0036	should be ind Mental i marked c	To B	PATRICK J.	KELLY,		SR.	ANN			BTAINABLE
Mar	ith ar 27 is r trau		19a. Informant's Name/Relationship (Type MIRIAM WINDER KELI	-		ng Address <i>(Street a</i> D6 WOODLAI			r, City or Town, Sti RVILLE, I	
ē,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other place		and the same of th	20c. Location - Ci	
altimore,			1 X Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State		CEMETERY	. 1	/2004	WOODLAW	N, MD
alti	permit. Peg Department Importent: I eny injury o		21. Signature of Funeral e vice Licensed		2	2. Name and Addres			SON & BRO	
<u> </u>	Per Dep du mb		Koberthi		1	3900 REIS	TERSTOWN	ROAD -	PIKESVILI	LE, MD 21208
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Dilated	Car	dromy	opath	1		Orisot and Death
3	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	10 00	1,	-		
×		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a donsed	uence of):	Atrial	paril	alwn		
/	nted Insit	min	Cause (Disease or injury				1			
Ć.	cate be executed oblysicien and the burial-transit	Examin	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	cate be ohysicie the bur	dlcai	d.							
89	ntifica ng ph	Med	IF FEMALE:							
Вох	death certifice attending ph I for use as th	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta	I death 3	Ectopic pregnancy			23d. Date of Month	
O.	e dea the at	sici	1 Yes 2 No	4☐Pregnant at time of d 9☐ Unknown	eath 5[Other (specify)			, , , ,	, buy tou
P.0	that the de led by the a detached (Part II. Other significant conditions cont	ributing to death but not res	ulting in the s	inderiving cause give	en in Part I.	23e. Did to	bacco use contribi	ute to the cause of death?
of Vital Records,	ng peq	d by			J	, ,		1 🗆 Y	es 2 No 3	Probably 4 Dunknown
Ö	w requir been si should	Completed						24a. Was a	an 24b We	re autopsy findings available
Re	The lav	m C						autop: perfor	sy prode	re autopsy findings available or to completion of cause of ath? Yes 2 No
tal		ده	25. Was case referred to medical				26. Place of Dea	th (Check only or		THIS ZEMINO
Ž	Physicien: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	espital: 1 ☐ Inpatient 2 ☑	ER/Outpatie	nt 3 DOA Othe	26	77-77-78-7	ence 6 Other	(Specify)
0	ding Ph h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury Work	at c?	28d. Describe h	ow injury occurred	
Siol	endir eath. or: Al	atlc	2 Accident investigation			M 1 []	Yes 2□No			
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st y)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	pitel ours a erel E		29a. Certifier 1 Certifying Physi	cian: To the best of my kno	wiedne door	h occurred at the time	ne date and place	and due to the	ausols) and man	er as stated
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director After this certific completely filled in by the funeral director.	Medical		er: On the basis of examina and manner stated.						
	To the vithin To the comple	₩ W	29b. Signature and title of certifier			29c. License			29d. Date signed (
	->		Mikerles	1		123	377	-	Januar	4 27, 2004
	10		30. Name and address of person who con	npleted cause of death (item		Print)	Ν Λ .	1	Dald.	Ne, M.B. 21215
			A. MAHAJABIN	S. ALI, M.E		401 West	Belved	M AVC.	Daum	oc, M.D. 21215
1	Sta Registr		31. Date filed (Month, Day Year)	32. Registrar Stgna	iture \$.	1 0	-			

ORIGINAL

Patrick Kelly

	1 = For State Registrar	State of Marylan	-	artment of		and Me		ene 200L	02512
Physician /Medical Examiner	1. Decedent's Name (First, Middle, L HALLES 4a. Facility Name (If not institution, gi	YENRY LEG	,	4b. City, Town,		of Death	Date of Death Month	Day Year	
Funeral Director	212 34 6970	Sex 7. Age (In yrs.		If Under 1 Yea Months Days		24 Hrs. 8. Min.	Date of Birth (Month, Day,	1920 M	O thplace (State or Foreign ountry) BYY / SNAO
with the Maryland or 28a-f show be nytilled at	Usual Residence of Decedent 10a. State 10b. County May And 10e. Street and Number	10c. Cit	BALL	10f. Zip Code			10	g. Citizen of What C	10d. Inside City Limits 10d. Section 10d. Inside City Limits 10d. Inside City Limits 2 □ No ountry?
urs after death with the st. or Hems 23a or 28a or	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1. BYes 2 \(\text{No}\) No If Yes, Give Year or Dates: \(\text{U} \text{V} \)		Was Decedent of f Yes, specify Cu			y Yes or No- an, etc.)	14. Race - Am Bleck, Whi	te, etc.
ed within 72 hourygiene. Ner than "naturaler, the Medical E.	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education	16a. Dece	dent's Usual Occ kind of work don DO NOT use reti	e during mos	,	F	6b. Kind of Business Drivate Fr	
should be file nd Mental Hy marked othe umatic event. To Be C	17. Father's Name (First, Middle, Las WIKLIAM 19a. Informant's Name/Relationship	OUDEN		ng Address (Stre	CA :	HEVI P	Route Number,	aiden Sumame) City or Town, State,	Zip Code)
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or othar trae once.	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	cemetery, crei	esition (Name of matory or other p	(ace)	1-2	6-042	1 MOR, NO. Oc. Location - City of INS MILE HARRIS	CU 212 YY Town, State L. Thory h
Physician /Medical Examiner Examiner	23a. Part / Enter the disease, or co shock, or heart failure. List on lamediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events	Due to (or as a consect Due to (or a))).	ith. Do not enting the control of th	der the mode of d	ying, such as	for	espiratory arres	st,	Approximate Interval Between Onset and Death
ath certificate be trending physicie or use as the bur an/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a consect of d. 23c. If yes, outcome of pregnature birth 2 Fete of consect of time of consect of the consect of	ancy al death 3[⊒Ectopic pregnar				23d. Date of de Month	elivery Day Year
w requires that the debeen signed by the a should be detached the detached by the second by Physic leted by Physic	Doh	contributing to death but not res	sulting in the u	nderlying cause	given in Part			s 2 No 3 P	to the cause of death?
sician: The law requir certilicate has been s rector, page 2 should	25. Was case referred to medical examiner?	Hospital:			Whon		autopsy perform 1 ☐ Yes 2 Check only one	ed? death? 1 Ye	s 2 No Assistes
tending Physicath. Ior: After this the funeral di	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. In W	jury at fork?	No 28		w injury occurred	- Living
To the Hospital or At within 24 hours after d To the Funerel Direct completely filled in by Medical Certiff	29a. Certifier 1 Certifying (Check only ane)	Physician: To the best of my known aminer: On the basis of examination and manner stated.	owledge, deal	ivestigation, in m	opinion, dea	nd place, and ath occurred	d due to the cal at the time, da	use(s) and manner a te and place, and du	e to the cause(s)
within com	30. Name and address of person with	o completed cause of death (Ite	- 00-) (7) 7	nse number 362 alc Rc			d. Date signed (Mor	04
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign					-0.00(0		

RPD)		1 - For Amend Items 23a, I Registrar Amend Item#11;	State of Ma tI,II,27,28 erINFG8282/	aryland / Der a-fper ME 68 4/04 EW	partment of I	Health and	Mental Hyg	iene 004	02613
	Physici	an	Decedent's Name (First, Middle, Last Linda		Lee			2. Date of Death Month	n Day Yeer	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	street and number)	nee	4b. City, Town,	or Location of De	January	7 26, 2004 4c. County of Death	2355 P M
	CXAIIIII	E	Union Memorial Ho			Baltimo			NA	
· · · · · · · · · · · · · · · · · · ·	Funeral Director		5. Social Security Number 6. Se 214-62-7745	াম এছিল	e (In yrs. last birthda) 50 Yrs.	// If Under 1 Year Months Days			9. Birthr Cour 53 Md.	place (State or Foreign ntry)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	Mary	tor	Md. NA		Ва	ltimore				1 X Yes 2 □ No
	th the or 288	Director	10e. Street and Number		1	10f. Zip Code		10	og. Citizen of What Cour	ntry?
	ath wi	ral	3204 Westerwald				.218		USA	
396	hours after death with the Maryland tural', or itema 23e or 28e-f ahow al Experiment count for motified at	by Funeral	11. Marital Status 1 ▼Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of I If Yes, specify Cub		(Specify Yes or No- arto Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
2-0	72 hours natural', dical Ex	eted	15. Decedent's Edu (Specify only highest grad	ication	16a. Dec	edent's Usual Occu	pation	rorking	16b. Kind of Business/In	dustry
21215-0036	I within 72 hours ilene. r then "neturel",	Completed	Elementary/Secondary (0-12)	College (1-4or 5	0+)	e kind of work done DO NDT use retire		9		
9	be filed v ital Hygie id other t event, th		12th grade 17. Father's Name (First, Middle, Last)		IN	ever Work	1	ame (First, Middle, N	NA faiden Sumame)	
Maryland	d ta b 💂	o Be	Roosevelt		Lee, Jr	•	Mary	L.	Jacks	on
ary	s 1 and 2 should f Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mai	ling Address (Street	and Number or	Pural Route Number,	City or Town, State, Zip	Code)
	1 and 2 Health lem 27 i			other			vald Ave	., Baltimo		.218
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 8			ematory or other pla			20c. Location - City or To	
Him			 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens 			vary Cem.			Anne Arunde	il Co., Ma.
Ba	permit. Departr Imports any inju		40-0	42 a	1. ()	March F.			ore, Md. 2 . North Ave	21202
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused	the death. Do not e	nter the mode of dy	ng, such as cardi	ac or respiratory arre		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CON	LIIAGOLI	and Ethan	Intoxic	and the same of th	LISM	Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):	,,,,		7,		
	- Zammer	-	Saquaritally list conditions,	Due to (or as	a consequence of):					
	uted J Insit	Examine	Sagus ilially list conditions; if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•	2 3011304201100 01).					
ó	exect an and rial-tra		that initiated events resulting in death) Last	Due to (or as	a consequence of):					
8760,	sate be executed by sician and the burial-transit	Icai		d						
9	entifica ding pl	9	IF FEMALE:	000 16.000 0000000						Carte Control
.O. Box	that the death certificate be executed to by the attending physician and detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Stanknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of delive Month	ory Day Year
S, P.	8 7 8	by P	Part II. Other significant conditions co			underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to th	e cause of death?
Vital Records,	w require been signature		Complications of (AILOUITC AICO	nolism			1 🗆 Yes	_	ably 4 Unknown
eco	law as b 2 sl	ompieted						24a, Was an autopsy	prior to cor	psy findings available mpletion of cause of
al F	ate pag	0						perform 1) Pyes 2	ed? death?	2 No
Z.	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No	lospital: 1 ☐ Inpatie	int 2 ER/Outpatie	ent 3 DOA Oth	The state of the s	eath (Check only one	·	
of		-	27. Manner of Death	28a. Date of Injur	ry 28b. Time	of 28c. Inju	ry at	28d. Describe how	nce 6 Dother (Specify w injury occurred	"
ion	fe A. P. din	atio	2 Accident 5 Pending investigation	01/26/200	LÔŒIG -	M 1	rk?]Yes 2. [XXNo	Unknown		
Division	l or Atten after deat Director: In by the	Certification:	3 ☐ Suicide 6 ♠ Could not be determined		ury - At home, farm, s	treet, factory, office			eet and Number or Rura State)	
۵	urs af urs af srel D				Dwelling			Baltim	ore, MD	
	To the Hospital or Al within 24 hours after of To the Funerel Direc completely filled in by	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 1 ☐ Certifying Phy Medicel Exami	sician: To the best oner: On the basis of and manner sta	examination and/or i	ith occurred at the ti nvestigation, in my o	me, date and plac opinion, death oc	ce, and due to the car	use(s) and manner as st te and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
			· / /	V.M		O.C.	M.E.		January 27,	2004
	3		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type	n Print) 11 Penn S	treet. F	Baltimore	Maryland 2	1201
	Sta	te.	31. Date filed (Month, Pay, Year)	32 Registra	ar's Signature				THE YEAR Z	エケハエ
	Registr		FEB 0 2 200			site!				
DH	MH 17 Rev 1/2	001	7 32 0 7 3	1-20-20	- 1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth d **Physician** /Medical 4b. City, Town, or Location of Death Fecility Name (If not institution, give street and number) 4c. County of Death Examiner U (com -104 V40,114 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months 1 □ M 2 🗓 F 78 Director 218-22-6250 March 21,1925 Maryland Usuel Residence of Decedent 10d. Inside City Limits filed within 72 hours efter death with the Merylenc 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 🏋 No Director r 28a-f Elkridge Howard 10f. Zip Code 10a. Citizen of Whet Country? 10e. Street end Number r than "naturel", or items 23e or the Medical Examiner must be 6524 Fallston Road 21227 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11, Marital Status 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2XXNo Specify: White Baltimore, Maryland 21215-0020 Specify <u>۾</u> 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) end Mental F Peges 1 end 2 should be Ida Marks Nelson Smith 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Heelth e if Item 27 is or other tra Robert Lease (Son) 6524 Fallston Road, Elkridge, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 02/02 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 2004 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses 12 Ridgely Avenue, Annapolis, MD 21401 alle 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examillar Examine bunel-trensit The law requires that the deeth certificate be exacuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) the 98 ettending properties of 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the To Yes 2□ No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yus ZINO 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this funeral 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide 0 within 24 hours eff To the Funeral Di completely filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. Ligagse number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 10/03 Kazlol 31. Date filed (Month, Day, Year) 32 Registrer's Signature State 0 2 2004 FEB Registrar

			1 - For State Registrar	State of M	aryland / Dep	artment of F			(5 on "	004	02615
					<i>Ce</i>	runcate or	Deam		Reg. No.		
П	Physici	an	1. Decedent's Name (First, Middle, Las	()				2. Date of Dea	Day	Year	3. Time of Death
	/Media		Many Lopes					January			1225PM
	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, or				nty of Death	
			Northwest Hospitz			If Under 1 Year	Ills town			iltimo	
5	Funeral		5. Social Security Number 6. Se	x	ge (In yrs. last birthday) 7 O Yrs.	Months Days		lin. (Month, Da)	y, Year)	9. Birth	place (State or Foreign ntry)
	Director		217-22-4233 Usual Residence of Decedent		78 Yrs.			01 3	0 25	N	1D
	and w		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Aary Fsho	ŏ	MD D-151								1 ☐ Yes 2 ☐ No
	28a-	Director	MD Baltimor 10e. Street and Number	.re	Catonsvi	10f. Zip Code			10g. Citizen o	of What Cou	ntn/?
	with a or			7 m t D		,	20				,
	eath	Funeral	220 Melvin Ave	12. Was Decedent	Ever in U.S. 13	212		/Specify Ves or No.		S.A.	
	ter d	'n	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀		If Yes, specify Cuba	an, Mexican, Pu	(Specify Yes or No- terto Rican, etc.)	В	lack, White,	
99	Irs al	by	Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2🏋 No	Specify:		Spec	cify:	Black
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-1 show with the Madical Examiner wast be notified at	Completed by	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation		16b. Kind of		
7	nin 7.	pie	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or	life	kind of work done of DO NOT use retired	during most of a d)	working			,
2	in the	E O	12th grade	2yrs		les Per	son		Re	etail	
ğ	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)	- N				Name (First, Middle,			
Maryland	Mental Ked o	To B	Leigh Allen				Agnes	Smith			
ary	should ind Men s marke umatic	Γ.	19a. Informant's Name/Relationship (7	уре, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Numbe	r, City or Tow	n, State, Zip	Code) 21043
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Mydical Examiner was the notified at		Denise Pinnick-	Daughte	r 8403	old Fr	edrick	Road,	Ellica	ott C	
Baltimore,	of Heid of Heid fitem		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place		Date	20c. Location		
Ë	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	1	•	. 1	1/28/0	e Balt	imor	o Md
Ī	permit. Pages Department of Important: If it any injury or o		21. Signature of Faneral Service Licens		/ 2:	2. Name and Address	ss of Facility		Dar	LIMOL	e, na
ä	Dep Imp		MADA	Masi	M	arch F/	H West	D = 1 to			01015
			23a Part 1. Enter the disease, or comp	lications that cause	d the death. Do not en	er the mode of dyin	asn AV	re, Balt:	Imore rest.	ма	21215 Approximate
t			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each l	ine.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. MYC	cardial (nfarction	n.				
н	Examiner										
1.3	M. 3	e	Secularitially list conditions if any, leading to immediate	Due to (or as	a consequence of):	IZVE				1.7	
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
^	al-tra	Xa	that initiated events resulting in death) Last	c. Due to (as	a conseq ence of):	21.8.5				_	
8760,	icate be executed physicien and s the burial-transit	dicai		d						ĺ	
289	ficate phy s the	edic		u							
×	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					234 0	ate of delive	any
Box	atter I	Physician/M	in the past 12 months?	1□Live birth 4□Pregnant a		Ectopic pregnancy Other (specify)	•			Month	Day Year
o.	the d y the	ysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown							
0	res that the de signed by the a be detached t	P.	Part II. Other significant conditions co	ntributing to death t	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use co	ntribute to th	ne cause of death?
Records,	sign sign ld be	d by						1 □ Y	es 2 No	3 ☐ Prob	ably 4 Dunknown
Ö	w require been sis	ete						-		10/	
Š	has 9e 2	Completed						24a. Was a autop: perfor	sy	prior to co death?	psy findings available mpletion of cause of
a								1 ☐ Yes	2.2 No	1 🗌 Yes	2□ No
Vital	Physician: this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Othe	or	eath (Check only or			
ō	0 = 0	٦.	1 ☐ Yes ②☐ No 27. Manner of Death	28a. Date of Inju		IL 3 DOA	4 🗆 Nursing	Home 5 ☐ Resident Re			y)
n	ding F n. After funer	ē	1 Natural 5 ☐ Pending	(Month, Da	y Year) Injury	Work	k? K? Yes 2 □ No	200. Describe in	ow injury occu	11100	
S	or Attendate death Director:	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e Place of In	ury - At home, farm, str		103 2 110	28f. Location (S	troot and Nur	abor or Pur	al Pouto Number
Division	or A after Direction by	ertii	4 Homicide determined	building, et	c. (Specify)	eet, factory, office		City or Town	n, State)	Der OF HUIZ	ir noute Number,
	e Hospitel or Attend 24 hours after death e Funeral Director: A etely filled in by the f		29a. Certifier 1/ Certifying Phy	sician: To the best	of my knowledge, deat	a neguerod at the time	ne data and ri-	non and due to the	nounce/=\		Interd
	Hos 24 ho Fun stely	edicai	(Check only 2 Medical Exam	iner: On the basis of and manner st	if examination and/or in	vestigation, in my of	pinion, death oc	curred at the time, d	ause(s) and n late and place	nanner as si , and due to	tated. the cause(s)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attended in by the fune completely filled in by the fune	Med	29b. Signature and title of certifier			29c. License	e number	2	29d. Date sign	ed (Month	Day, Year)
	⊢ ≯ ⊢ ŏ		Mauria 1	ujia	. MD				_		•
			20 Name and other Color	amalate # == ·	teeth (lie = 22:) =	DO 0	6050	†		y -3,	7
	2		30. Name and address of person who c			Print)	Carte	oad Ran	dollah	3414 14	2004 Varjand
	Sta		31. Date filed (Month, Days Near)		s Signature	1 2				-VVII	variation
	Sta Registr		FEB 0	Z ZUU4 2	Rolling St.	marke					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Philip Lindenberger 0620M 0 30 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner University of Manyland Judical Center Baltmore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1**∑**M 2□F 213-34-1817 67 10, 1936 WASHINGTON D.C Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral, or items 23a or 28a-f show Examiner matal be notified at 1 X Yes 2 □ No MARYLAND TALBOT EASTON Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21601 U.S.A. 26 KENSINGTON DRIVE Funera 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after the last hand Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 *natural', or If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) GROCERY Elementary/Secondary (0-12) College (1-4or 5+) 12 GROCERY STORE MANAGER STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If Item 27 is marked out eny injury or other traumatic even since. PHILIP DORMAN LINDENBERGER HELEN ELIZABETH MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MELVINA MAY LINDENBERGER/WIFE 26 KENSINGTON DR., EASTON, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) ST. MARY OF THE MILLS 2/3/2004 LAUREL, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME, Set P. Gr 16000 ANNAPOLIS ROAD, BOWIE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Multiple Mydioma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Minpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending Natural 2 Accident 5 Pending Injury investigation Director: / 3 🔲 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) iconico Morane LO 01/30/04 F16469 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bellhimore ND 21201 Kathleen Brennan Street UZ South Greens 31. Date filed (Month, Day, Year) 32/Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2 2004

G

			For	Please	Type or Pri State of M		d / Depa	artmen	t of H	lealth a		•			e.	0001-
	Physici		1 - State Registrar 1. Decedent's Name		w Mary Link		Cei	rtificate	e of i	Death		. Date of De . Month	Day	Y .	ar 4	3. Time of Death
Nc.	/Medic Examir Funeral		4a. Facility Name (If I	not institution, give	street and number,	timo ge (In yrs. le	√ e ast birthday)	If Under	1 Hi Year	Location of	Death Cifu 4 Hrs.	4 . 1	Ø 4c.	County of	Death Birthola	ice (State or Foreign
	Director		215-28-95 Usual Residence of D		□ M 2 □ X F	72	Yrs.	Months	Days	Hours	Min.	Date of Bir (Month, Da Aug.	y, rear)	931 N	lary	Land
	death with the Maryland ms 23s or 28s-f show Entate be rediffed at	Director	Md. 10a. State	10b. County Baltimor	·e	1 '	Town or Lo		0-4-				10 - 011	/ 148		d. Inside City Limits 1 Yes 2 No
	s 23a or	ral Dir	134 W	Vilgate F				2	2111						5.A.	
2-0036	n 72 hours atter death with the Marylan "natural", or Items 23a or 28a-1 show calcal Exar'ulter matal be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		12. Was Decedent Armed Forces: 1 ☐ Yes 21☐ If Yes, Give Year or Dates:	?		Was Decedon fYes, spec 1 ☐ Yes 2		ispanic Origi n, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No ≎an, etc.)	- 1	14. Race - Black, \ Specify: \forall	White, et	c.
1215-	within 72 h iene. • than "netu it e Medica	Be Completed	(Specify	15. Decedent's Ed y onfy highest grad dary (0-12)	ucation de completed) College (1-4or	5+)	(Give life. l	dent's Usua kind of wor DO NOT us DUSEW	k done d e retired	ation furing most o)	of working			nd of Busin Omemak		istry
and 2	be filed ital Hyg id other event,	To Be Co	17. Father's Name (F	irst, Middle, Last) Wojcik	J	l				18. Mother's		First, Middle,		,		
, mary	s 1 and 2 should of Health and Men item 27 is marke other traumatic	-	19a. Informant's Nam Deborah A.	ne/Relationship (T			20 Ri	dgelav	wn R	d., Re						Code)
aitimore	vermit. Pages 1 Department of H. mportant: If iter iny injury or oth		° 4 ☐ Donation 5	Cremation 3 🗆				Vetera	ans	Cem. I	Date Feb.			cation - City		n, Stete
Dai	Depar Impor Impor any ir		21. Signature of Fund	7. Zeli	bardt	2		Eckhar L1605	rdt Rei	s of Facility Funera sterst	town	Rd ()wine	s Mil	ls,	Md. 2111
	Physician /Medical Examiner		23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List only o	one cause on each li	ne.	Do not ente			g, such a <i>s</i> ca	ardiac or re	espiratory a	rest,		l le	Approximate of the property of
,	executed in and ial-transit	Ilcal Examiner	Sequentially list conding any, leading to immicause. Enter Underhocause (Disease or in that initiated events resulting in death) La	st	b. Due to (or as c. Due to (or as		·									-
O. DOX O	To the Hospital or Attending Physician: The law requires that the death certificate be execu- within 24 hours atter death. To the Futerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tra-	Physiclan/Medlca	IF FEMALE: 23b. Was decedent print the past 12 mm 1 Yes 2 9 Unknown	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 🗌	Ectopic pre					2	3d. Date of Month		ay Year
ecords, r	en signed b	þ	Part II. Dther signific	_	entributing to death b	ut not resul	ting in the ur	nderlying ca	use give	n in Part I.			obacco us			cause of death?
אוומוו אפכר	n: The law re licate has be r, page 2 sho	Completed											an sy rmed? 2 No	24b. Were prior death	to comp	y findings available eletion of cause of
5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	To the Hospitel or Attending Physician: The law within 24 hours after defector. After this certificate has I To the Funerel Director. After this certificate has I completely filled in by the funeral director, page 2 s	atlon: To Be	25. Was case referred examiner? 1 Yes 2 No. 27. Manner of Death 1 Natural 2 Accident	(1)	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		P/Outpatient 28b. Time of Injury		c. Injury Work	r: 4 🗆 Nursi	ing Home 28d	theck on ⊨ o 5 ☐ Resid . Describe h	lence 6		Specify)	
	itel or Atters and sel Directoried in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At hoп c. <i>(Specify)</i>	ne, farm, stre	et, factory,	office		28f.	Location (S City or Ton	Street and m. State)	Number o	Rural F	loute Number,
	in 24 hou in 24 hou ine Fune pletely fil	edical	29a. Certifier 1 (Check only 2 one)	☑ Certifying Phy ☐ Medical Exam	rsician: To the best iner: On the basis o and manner st	t examinatio	ledge, death on and/or inv	occurred a estigation, i	t the tim in my op	e, date and p inion, death	place, and occurred a	due to the dat the time, d	cause(s) a date and p	and manne place, and	as state due to th	ed. e cause(s)
	with To COM	M	29b. Signature and tit	m	2 MC)				number)			signed (M		
	10		30. Name and address	GRT L.	HON6	, m	23a) (Type, F	Since	ui	100C	pito	of o	f 1	Balt	mo	re
	Sta Registr		31. Date filed (Month.	2 2004	32. Hegistr	ars signatu	posts			· ·	•					

			1 - For State Registrar	State o	of Maryla		artment of H tificate of I		d Mental Hy	ygiene Reg. No	21111	02618
	· **		1. Decedent's Name (First, Middle, La	st)			-		2. Date of D	eath Da	y Year	3. Time of Death
	Physici /Medic		William C.	Line					Januar	y 29°	2004	12:17 p M
6	Examin		4a. Facility Name (If not institution, giv	street and nu	mber)		4b. City, Town, or	Location of De	ath	40	. County of Deat	h
			Carroll Hospita	1 Cente	er		Westmin				Carro1	.1
	Funeral		5. Social Security Number 6. S	ex CIM 2□F		s. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi	in (Month, D	av. Year	Co	hplace (State or Foreign untry)
	Director		214-42-1819	W ZUF	60	Yrs.			June	28,	1943 Ma	ryland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. 0	City, Town or Lo	cation					10d. Inside City Limits
	f sho	ō	MD Carrol	1			Finksbu	ro				1 ☐ Yes 2 🛣 No
	288-	rect	10e. Street and Number				10f. Zip Code	- 6		10g. Ci	tizen of What Co	untry?
	death with the Maryland me 23s or 28s-f show [Trust Le notified at	Funeral Director	2551 Baltimore	R1vd			2104	48		T	J.S.A.	
	ne 2	lera	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13. 1	Was Decedent of H	ispanic Origin?	(Specify Yes or N		14. Race - Ame	
0	r Her	F	1 ☑ Never Married 2 ☐ Married	Armed Fo	2 🔯 No		f Yes, specify Cuba		erto Rican, etc.)		Black, White	e, etc.
2	ours a	by	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve)ates:		I ☐ Yes 2 ☑ No	Specify:			Specify: W	hite
ָ ה	72 ho	Completed	15. Decedent's Education (Specify only highest gra	Jucation de completed)		(Give	lent's Usual Occup	durina most of w	vorking	18b. K	(ind of Business/	Industry
7	ithin	npi	Elementary/Secondary (0-12)	College (life. I	DO NOT use retired	1)		0.5		-1.4.4
V	filed within 72 hours after Hygiene. sther than "natural", or Ite sther than "natural" sont.		9				Truck Dr		lame (First, Middl			altimore
nand	be fi	Be	17. Father's Name (First, Middle, Last, William E		16				Alice		Stauffer	
Š	2 should be filed within 72 hours after death with the Marylan and Mental Hygiens. Is marked other than "natural", or Itema 23a or 28a-1 show at marked other than "natural", or Itematic event, the Madical Exertifier mast be notified at	To	19a. Informant's Name/Relationship (10h Mailir	g Address (Street					
2	d 2 sh h and 7 is r treur		Richard L. Line	Brot	hor		Greenmead					
บ้	1 and Health em 27		20a. Method of Disposition			Place of Dispo	sition (Name of		Date	-	ocation - City or	
2	Pages nent of int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				matory or other plac w Mem. Pa	1.	1/0/	Carle	esville.	MD
Saithnor	그 문문을 .		21. Signature of Funeral Service Licer		L		. Name and Addres		11824 Re	-		
Ö	Depa Impo any ii		Kamb Q	Plan			LINE FUNE					21136
			23a. Part1. Enter the disease, or com	plications that	caused the de							Approximate
	Physician		shock, or heart failure. List only immediate Cause (Final	one cause on a	each line.							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	(or as a cons	equence of):			 			year 7
	Examiner				,	,						
-		Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to	(or as a conse	equence of):						
	cuted nd ransi	Examiner	that initiated events	C.								
5	a exe	EX	resulting in death) Last	Due to	(or as a conse	equence of):						
0/0/	cate be executed physician and the burial-transit	dicai		_ d								
٥	ing pl	Med	IF FEMALE:			7.17						
X O O	ath ce	Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth 2 🗀 Fe	etal death 3	Ectopic pregnancy				23d. Date of deli Month	very Day Year
5	he de	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9∐Unkn	nant at time of lown	death 5L	Other (specify)	-	· · · ·			
7	sicien: The law requires that the death certific certificate has been signed by the attending frector, page 2 should be detached for use as		Part II. Other significant conditions of	ontributing to d	eath but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Ď	sign d be	d by				-	,		1 🗀	Yes 2	□No 3□Pro	obably 4 Unknown
ecords	v req been shoul	ete			, , , , , , , , , , , , , , , , , , , ,				24a. Wa	s an	24h Ware au	topsy findings available
Ď	has ge 2	Completed							- auto	opsy formed?	prior to death?	completion of cause of
VII	n: Ti ficate or, pa		25. Was case referred to medical					OC Plans of D	1 ☐ Yes eath (Check only	20 No	1 ∐ Yes	2□ No
	Physician: r this certific ral director,	o Be	examiner?	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Oth	an.	Home 5 Res		6 MOther (Soe	rifu)
5	Phy er this		27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Injun	/ at	28d. Describe			
SION	Attending ir death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation		nth, Day Year)	Injury	Worl M 1 □	K? Yes 2 □ No				
<u>></u>	Atte	iii Ci	3 Suicide 6 Could not b	289. Flace	e of Injury - At ling, etc. (Spe	home, farm, str	eet, factory, office		28f. Location	(Street ar	nd Number or Ru	ral Route Number,
2	s after sale or Certification:		Julia	mig, oto. (opo						7		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page						occurred at the time vestigation, in my of					
	the Hin 24 the F	Medicai	one)	and man	ner stated.							
	With To 1	2	29b. Signalute and title of certifier		\sim \cap	1 IM	29c. License				te signed (Month	
	6		1 1 m	ev Y	- 1	1 111		51924		Janu	ary 30, 2	1001
	1)		30. Name and address of person who						0	. 2		
	/		31. Date filed (Month, Day, Year)		Registrar's Sig	nature :	P.C. Man	chestic	mO zuo	7		
	Sta Registr			2004	MERZYAN.	, it	Local 1					

		1 - For State Registrar	State of Maryland / De	epartment of Health and Certificate of Death	Reg. No	- UU + UZOI
Physicia /Medic	al	1. Decedent's Name (First, Middle, Last	Clain	4b. City, Town, or Location of Deat	2. Oate of Death Month Da	3. Time of Death
Examin Funeral Director		5. Social Security Number 6. Se 218 76 6752	laryland Medical Center	R Baltimore tay) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month. Day, Year)	~/10
r 28a-f ehow	Irector	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number		or Location Haux 101. Zip Code	10g. Cit	10d. Inside City Limi Ves 2□N
nous are cean min ne wayane turef, or fams 23a or 28a-f ehow al Examiner must be notified al	by Funeral Director	45. Mf. OLIVET 11. Marital Status Never Married 2□ Married 3□ Widowed 4□ Divorced		13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 25 No Specify:		14. Race - American Indian, Black, White, etc.
iene. r then "na	Completed t	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	(College (1-4or 5+)	ecedent's Usual Occupation Sive kind of work done during most of wo fe. DO NOT use retired) SE/CELPING	rking Peril	Kind of Business/Industry
Mental arked c	To Be	17. Father's Name (First, Middle, Last) JESSIE AL MC 19a. Informant's Name/Relationship (Ti		-	me (First, Middle, Maiden	-K
f Health and Itam 27 is m other traum		MARIE McC/A1 20a. Method of Disposition	N/MOTHEN 4	5. Mt OLIVET LA	ne Bolts	nore Md 2122
Department of Important: If it any injury or o		*** Burial 2 Cremation 3 : 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Vicens Using Fully	Removal from State Cometery.	isposition (Name of crematory or other place) 2. Name and Address of Facility 2. Name and Address of Facility 3. Place of the company of t	Pate / 20c. L.	BUTUS Merylm
nysician Medical Medical xaminer	Examiner	23a. Party Enter the disease, or compension, or heart failure. List only of immediate cause (Final disease or condition resulting in death) Sometimes of the conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. hpoxi'a Due to (or as a consequence of) Due to (or as a consequence of)	Injury (3 wee		Approximate Interval Between Onset and Death
physician and streets the burial-transit	cal	that initiated events resulting in death) Last	c. Cardiac - Due to (or as a consequence of)			
by the attending phy tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
signed d be de		Part II. Other significant conditions co	ntributing to death but not resulting in the		23e. Did tobacco i	use contribute to the cause of death?
	Completed by	Trachoesophage	al Fistula, card	iomyopethy	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy findings availa prior to completion of cause death? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)
nis certific	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ♠ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outp	Othor	ath (Check only one) Home 5 Residence	6 ☐Other (Specify)
death. stor: After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Tin Inju 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number,
within 24 hours after To the Funeral Direct completely filled in by	Medical Co	29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best of my knowledge, of the basis of examination and/of and manner stated.	leath occurred at the time, date and place or investigation, in my opinion, death occurrence.	, and due to the cause(s urred at the time, date and	and manner as stated. d place, and due to the cause(s)
within To the comple	Me	29b. Signature and title of certifier Wath Jen		29c. License number	29d. Da	nte signed (Month, Day, Year)
)	te	30. Name and address of person who c KRISTIN Flam 31. Date filed (Month, Day, Year)	ompleted cause of death (Item 23a) (Tymer University 1978)	of Meryland 22	2 South Gr	een Street Billm

		1	For State Registrar	State of Ma	ryland		irtment of H <i>tificate of L</i>				giene Reg. No.	2001	0262	20
			Decedent's Name (First, Middle, La.	st)						2. Date of De Month	ath Day	Year	3. Time of Deat	h
	Physicia		Sedrick Ivan	McAlliste	r						26	2004	12:15 a	М
	/Medic Examin		4a. Facility Name (If not institution, giv	street and number)			4b. City, Town, or	Location	of Death		4c.	County of Deat	h	
	LXamin	ζ'	Joseph Ritchie H	ospice		1	Baltimo					NIA		
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. las		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)	Co	hplace (State or Fore untry)	
	Director		217-64-5577	KDMM 2□F 5	<u> </u>	Yrs.				11-06-	1952	Nort	h Carolin	a
	D .	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation						10d. Inside City Lin	nits
	sho	5											1√∏Yes 2□	No
	Ne N	Director	MD 10e. Street and Number		ват	timor	10f. Zip Code			T	10g. Citi	zen of What Co	untry?	
	a or	급		r Vina Dlu	a		21201				US	7\		
	eath	Funeral	718 Martin Luthe	12. Was Decedent E		13. \	Was Decedent of H	ispanic Or	igin? (Spe	cify Yes or No		14. Race - Ame		
	ter d	FE	1 ☐ Never Married 2€ Married	Armed Forces? 1 ☐ Yes 2 ☑ 😾	0	'	Yes, specify Cuba	in, Mexical	n, Puerto i	lican, etc.)		Black, Whit		
Š	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2√xxXNo	Specify:	:			Specify:Bla	CK	
	72 ho	Completed	15. Decedent's E (Specify only highest gro	ducation de completed)		16a. Deced	dent's Usual Occup	ation	st of workin) g	16b. Ki	ind of Business	Industry	
,	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5		life.	DO NOT use retired	1)						
7	ygien rer th	ပ္ပြ	7th grade			Forkl	ift Drive		-4- 11	(First, Middle		borer		
2	tal H d oth	Be	17. Father's Name (First, Middle, Last									Jumame)		
2	2 should be filed within 72 hours after death with the Maryland and Merial Hygiene. Is marked other than "natural", or Items 23a or 28a-f show reumatic event, the Micrical Examinations to incitited at	ို	Sedrick McAlli			405 14-77	ng Address (Street		-	Wilso		r Tourn State	Zin Code)	
<u>a</u>	and raum		19a. Informant's Name/Relationship (
ນົ	1 and 1 eaith 1 m 27 ther tr		Elizabeth McAllis 20a. Method of Disposition	ter/wile	20b. Plac	ce of Dispo	artin Lut			ate		cation - City or		
2	Pages nent of H int: If its ury or o		1 ☐ Burial 2 € Cremation 3 [Removal from State			matory or other plac		01-20	-2004	D-1+	imoro	Maryland	
Dallinor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The man 21 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, tra Modical Examinat hast be notified at once.		* 4 □ Donation 5 □ Other (Special Service Lice		Metr		matory 2. Name and Addre			-2004	Daic	IMOLE,	Maryranu	
Ö	permit. Departn Imports any inju		21. Signature of turners of the	Denveru)	W	illiam C 206 W No	Brow cth A	n Con	munity Balf	Fun	eral Ho	me, P.A.	
			23a. Part 1. Enter the disease, or con	plications that caused	the death.							C) IID Z	Approximate Interval Between	,
\$ I	Dhusisian		shock, or heart failure. List only Immediate Cause (Final			I H.	e orop	la serie	nХ				Onset and Death	
}	Physician /Medical		disease or condition resulting in death)	Due to (or as	CeV O	nce of):	e orop	nor y	197				10/1-	
	Examiner													
	*3	Jer	Securitally list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	nce of):								
	cuted nd ransil	Examiner	Cause (Disease or injury that initiated events	c										_
Ş	e exe ian ar urial-t		resulting in death) Last	Due to (or as	a conseque	ince of):								
2/20	death certificate be executed e attending physician and d for use as the burial-transit	dical		_ d										
٥	ing pl	Mec	IF FEMALE:	20- 11	-1							001 0-1	16	
X Q Q	ath ca	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal d	death 3	Ectopic pregnancy Other (specify)	/			1	23d. Date of de Month	Day Year	
5	the de by the a ached f	hysiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟ Pregnant at 9⊟ Unknown	time or dea	ıın əl	_ Other (specify) _							
<u>7</u> .	that the death ed by the atte detached for	0_	Part II. Other significant conditions	contributing to death b	ut not result	ting in the u	inderlying cause giv	en in Part	l.	23e. Did	tobacco	use contribute t	o the cause of death	?
as,	requires that een signed b hould be dete	d by								10	Yes 2	□No 3 🗗 🗗	robably 4 □Unkn	own
ecord	w requires that been signed b should be deta	Completed								24a. Was		24b. Were a	utopsy findings avail	able
ě	e la has je 2	m d						~		auto perf 1 ☐ Yes	psy ormed? 2 4 No	death?	completion of cause	OI
Vital		CO	25. Was case referred to medical					26. Plac	e of Death	(Check only		7 10.10.		
	ystcian: is certific director,	0 8	examiner?	Hospital:	nt 2 E	R/Outpatie	nt 3□ DOA Oth					6 Dother (Spe	ecity) HOXD	ce
Division of	g Phy er thi	n:T	27. Man or of Death	28a. Date of Inju (Month, Da		28b. Time o	of 28c. Inju	ry at		28d. Describe	how inju	ry occurred	1.1	
0	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	on		,-,		Yes 2]No					
<u> </u>	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At homo. (Specify)	ne, farm, st	reet, factory, office			28f. Location City or To			ural Route Number,	
	itel o													
	Hosp 4 hou Fune ely (ii	ical	(Check only 2 Medical Exe	hysician: To the best miner: On the basis o	examination	rledge, dear on and/or in	th occurred at the tinvestigation, in my	me, date a opinion, de	and place, eath occur	and due to the ed at the time	cause(s , date an	 and manner a d place, and du 	s stated. e to the cause(s)	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29b. Signature and title of certifier	and manner st	100.		29c. Licen:					ite signed (Mon		
1	To Co.		G G A				*-							
,	D		0800	(A)	loath /lt	22a\ /T	Print)	711	-		Jam	rury ub,	0004	
	2		30. Name and address of person who	de Maria		7201	N. Eut.	J	Bal	timor.	e. N	lary 26, 1D 21	201	
	St	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	nte	And s				/	-		
	Regist		FFB 0 2	2004	THE .	At A	DONE!							

			For State Registrar	110000	State of N		d / Depa	irtment of	f Health	and Me	ntal Hyg	iene g. No. 20 () 4	02621
	Physici		Decedent's Name (Firs LAWRENCE	t, Middle, Last)	MARTIN					2	Date of Dear Month		Year /	3. Time of Death S.35 A M
	/Medic Examin	_	4a. Facility Name (If not in			r)		4b. City, Town	n, or Location	n of Death		4c. County o	f Death	
	Funeral Director		5. Social Security Number 139-44-9577	f 6. Sex		Age (in yrs. ia	st birthday) Yrs.	If Under 1 Ye Months Da		er 24 Hrs. 8 8 Min. A	Date of Birth (Month, Day) UGUST	Year) 23,1947	9. Birthplac Country	e (State or Foreign) MD
	anyland •how	2	Usual Residence of Dece 10a. State 10b. MD	County BALTIMO	DF.		, Town or Lo	cation					10d	. Inside City Limits 1 X Yes 2 □ No
	28a-f	Directo	10e. Street and Number	DALITIO				10f. Zip Cod			1	0g. Citizen of Wh	•	
net	ē = =	Funeral Director	324 SOLLER	1	ROAD 2. Was Deceder Armed Forces 1 Yes 2	s?	6. 13. Y	Vas Decedent of Yes, specify C	21222 of Hispanic (Cuban, Mexic	Origin? (Speci can, Puerto Ri	fy Yes or No- can, etc.)		A - American , White, etc	
Re-	*natural, or	þ		Divorced Decedent's Educ	If Yes, Give Year or Dates ation		16a. Decec	l ☐ Yes 2 💢 l	cupation			Specify:	BLAC	
21215	d within giene. rr than	Completed	(Specify on Elementary/Secondary	ly highest grade (0-12)	Completed) College (1-4o	r 5+)	life. L	kind of work do DO NOT use re GSHOREM	tired)	ost of working		SHIPPI	NG	
Maryland	ges 1 and 2 should be filed to of Health and Mental Hygi If item 27 is marked other or other treumatic event,	To Be C	17. Father's Name (First, FLOYD MART								First, Middle,	Maiden Sumame S)	
	1 and 2 sho Health and N Iem 27 ie me other treums	ľ	19a. Informant's Name/F					g Address (Stre VELCOME			IMORE,	, City or Town, S MD 212		ode)
Makt altimore,	Pages 1 are nent of Hearn of Hearn of Hearn of Hearn of Hearn of Hearn or other or other hearn o		20a. Method of Disposition 1 ☐ Burial 2 分Cre 4 ☐ Donation 5 ☐ 0	mation 3 Re	emoval from Stat	te Ce	metery, cren	sition (Name of natory or other EMATORY	place)	Dat 1-30	1.5	20c. Location - C		
Balti	permit. Page Department o Important: If eny injury or 2005.		21. Signature of Funeral	Service License	Mo	rton		. Name and Ad 701-31				ORTON & MORE, MD		F.H., INC.
	» Physician		23a. Part. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition	ease, or complicate. List only on	e cause on each	ed the death viine.	Do not ent	/		0 0			In	pproximate iterval Between inset and Death
	/Medical Examiner		resulting in death)		Due to (or a	erel	ence of):	Vas	Cilc	ar t	&ccizi	y disev		
W	be executed sician and buriat-transit	Examiner	Sequentially list condition if any, leading to immediacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ate o		as a consequ								
8760,	m 2 m	cal				as a consequ	ence or).							
Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certificat: r death. ordor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by Physiclan/Med	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	mant	3c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3	Ectopic pregna Other (specify				23d. Date Mont	of delivery h Da	ay Year
ds, P.	luires that the d signed by the vid be detached	d by Ph	Part II. Other significent	conditions con	tributing to death		lting in the u	nderlying cause	given in Pai	rt I.		bacco use contrib es 2 □ No 3		cause of death?
Recol	The law requir ate has been si page 2 should	Completed									24a. Was a autops perform	ned? pri	or to comp ath?	y findings available letion of cause of
Vital	ysician: Th is certificate director, pag	To Be C	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	_	ospital:	atient 2 1	=R/Outpatien	t 3 DOA	Other		Check only on			
ion of	utending Phy death. ctor: After this y the funeral of		27. Manner of Death	Pending investigation	28a. Date of Ir		28b. Time of Injury	28c. I	njury at Work? 1 🗆 Yes 2	28		ow injury occurre		
Divis	spitet or Attend nours after death nerel Diractor: /	Certification:	3 🗀 Suicide 6 🖂 4 🗀 Homicide	Could not be determined	28e. Place of building,	Injury - At ho etc. (Specify	me, farm, str	eet, factory, offi	ice	28	f. Location (Si City or Town	reet and Number n, State)	r or Aural A	Route Number,
1	표 전 교 ·	edical	29a. Certifier 117 (Check only 2010)	Certifying Phys Medical Examir	ician: To the be ter: On the basis and manner	of examinat	viedge, death ion and/or in	vestigation, in n	ny opinion, d	leath occurred	d due to the call at the time, d	ause(s) and manate and place, an	ner as state nd due to th	ed. e cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of		ouly 1.	thy s	Creh		ense numbe	2		9d. Date signed		
عبو	1		30. Name and address o	person who co	mpleted cause of	death (Item	23a) (Type,	Print) PaVIi	1 31	'vel	303	Balt	min	2004 e 2(239
	Sta Regist		31. Date filed (Month, Da	FEB 0	mpleted cause of 1 5 6 1 32. Regi	stran Signat	ure	Spark	E)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #30 PER DVR G828 2/02/04 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 21, 2004 JANUARY 8:30 P.M. KENNETH RUSSELL MURPHY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Allegany Frostburg Village 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 16, 1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days Hours 1⊠M 2□ F 81 212-12-8863 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits MD Director Allegany Frostburg 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Kaylor Circle 21532 Funeral USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2K Married 1 X Yes 2 ☐ No If Yes, Give 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 43–47 Be Completed by white 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) salesperson 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked or any Injury or other traumatic eve Marion Berry Murphy ဥ Clara Agnes Minnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keni Ann Watkins/daughter 201 Rynex Avenue Frostburg, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Finneral Sorvice Sicensee ade. ²³ State^{ad} Address of Facility</sup>Board 655 W. Baltimore Street Director. Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ALZINERS DEMENTIA About-6mm Examiner Due to (or as a consequence of) Physiclan/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or es a consequence of) Due to (or as a consequence of): resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? METABLIC ENCEPHALOSATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown <u>ک</u> Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1) Natural
2 Accident 5 Pending investigation 1 Yes 2 No

Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, erel Director: / within 24 hours e
To the Funerel C

3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number D 26967 Mulh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARJIT S. SIDHU FROSTBURG VILLAGE FROSTBURG, MD 21532

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 0 2 2004

32. Aegistrar's Signature John Pagage P

29d. Date signed (Month, Day, Year)

MNUARY 23 200 4

				nd / Depa	artment of Health and Nartificate of Death	-	ne 2001	. 02623
	Physici /Media		1. Decedent's Name (First, Middle, Last) Ella Na	nce		2. Date of Death Month	Day Year 22 200	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Dea	th
			MERCY HOSPITAL		BALTIMORE		N/A	
	Funeral Director		5. Social Security Number 6. Sex 1 日 M XXF 7. Age (In yrs. 217-55-7787 1日 M XXF 5. Security Number 1 日	last birthday) 2 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye JAN 26 19	ar) 9. Bin Co 951 N	thplace (State or Foreign ountry) IARYLAND
	tryland show	_		ty, Town or Lo	ocation			10d. Inside City Limits
	Ba-f s	Director	MARYLAND N/A	BALTI				1XXYes 2 No
	with the or 2		10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	ountry?
	leath	era	1224 DRUID HILL AVE. 11. Marital Status 12. Was Decedent Ever in U	I.S. 13.1	21217 Was Decedent of Hispanic Origin? (Sn	ecify Yes or No-	U.S.A.	ancan Indian
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If itsm 27 is marked other than "natural", or iteme 23s or 28s-f show injury or other treumatic avent, the Modical Examinan must be notified at as.	by Funeral	Armed Forces? 1 Nover Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2XXNo Specify:	Rican, etc.)	Black, Whit	
2-0	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	16b	. Kind of Business	
2	within 7 ene. than "r	npie	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most of work DO NOT use retired)	ing		
	filed w Hygier other ti		12th grade 17. Father's Name (First, Middle, Last)	HOM	IEMAKER	e (First, Middle, Maid	DOMESTIC	
Maryland	id be fental he ked of	To Be	WILLIE NANCE			reean nanc		
ary	should and Men s marks turnatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Rur	al Route Number, Cit	y or Town, State,	Zip Code)
	1 and 2 Health Ism 27 i		Peggy Nance/Sister	3421	Dolfield Ave., B	altimore,	Maryland	21215
ore	Pages 1 nent of He int: If itsr iny or oth		20a. Method of Disposition 20b. 20b	Place of Dispo cemetery, crer	osition (Name of matory or other place)	Date 20c.	. Location - City or	Town, State
Baltimore,	t. Pag tment tent: sjury		`4 ☐ Donation 5 ☐ Other (Specify) ARE	7.0	IEMORIAL 01-2	8-04 BA	LTIMORE,	MARYLAND
Ba	permit. Pages Department of t Important: If its any injury or o		21. Signatur Franeral Service Licensee / Signatur Properties De Sign	e I	2. Name and Address of Facility VILLIAM C BROWN CO 206 W NORTH AVENU	MMUNITY FU	JNERAL HO	ME P.A.
	Physician /Medical		234. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consec	tastal	er the mode of dying, such as cardiac Te meast C		vo-	Approximate Interval Between Onset and Death
	Examiner			1001100 017.				
	pg tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uence of):				
	xecut and al-tran	хап	that initiated events resulting in death) Last C	uence of):				
760,	ate be executed nysician and he burial-transit	calE	L _d ,					
89	ntificat ng phy as th		JE FEMALE					
Вох	tth cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Feta	ancy II death 3 □	Ectopic pregnancy		23d. Date of del	
O.	that the death certifica ed by the attending ph detached for use as th	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	eath 5	Other (specify)		Month	Day Year
<u>α</u>	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as it	þ	Part II. Other significant conditions contributing to death but not res	ulting in the un	nderlying cause given in Part I.	23e. Did tobacc		the cause of death?
Records,	w req	ete	thromboart newic of	HI DOW	10	24a. Was an	24h Were au	itonsy findings available
al Re	tician: The lav certificate has rector, page 2	Completed	Lepotic for luve 25. Was case referred to medical		1	autopsy performed	} death?	itopsy findings available completion of cause of
Vital	Physician: r this certificaral director.	To Be	examiner?	ER/Outpatien	Othor	n <i>(Chack only one)</i> me 5 ☐ Residence	6 COther (See	oifu)
J Of	ding Phys I. After this funeral di	n: T	27. Manner of Death 28a. Date of Injury	28b. Time of Injury		28d. Describe how in		sny)
Siol	andir eath. or: Af the fu	catic	2 Accident investigation	,,	M 1 ☐ Yes 2 ☐ No			
Division	il or Attano after deatl Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specific Could not be determined 5 ☐ Could not be determi	ome, farm, stre y)	eet, factory, office	28f. Location (Street City or Town, St.	and Number or Ru ate)	iral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known one) 2 Medical Examiner: On the basis of examination and manner stated.	wledge, death	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License number	29d. J	Date signed (Month	h, Day, Year)
)	10-		> My maked		D37790		famus	4 22, 2004
_	' り		30. Name and address of person who completed hause of death (Iter	1 23a) (Typ).	of Place Bald	mire M	0 212	02
Y.5.	Sta Registr		31. Date filled (Month, Day, Year) See 1. Date filled (Month, Day, Year) 32. Registrar's Signary 33. Date filled (Month, Day, Year)	iture	local			

		ate of Maryland / D	Department of I	Health and Me		e 2001.	02621
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Life is a first of the street	ER OWERS	4b. City, Town,	2. Or Location of Death	Date of Death Month Da Inuary 2	ay Year	3. Time of Death
	Sinai Rospital of 5. Social Security Number 6. Sex 23/54 97/6 Usual Residence of Decedent	f Baltimore 7. Age (In yrs. last bin 59		If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year		lace (State or Foreign stry)
C C (C in) death with the Maryland ims 23s or 28s-1 show timest be requified at	10a. State 10b. County Misry/Mas 10b. Street and Number	10c. City, Town	or Location BAI HERE 10f. Zip Code	Έ	10g. C	itizen of What Cour	0d. Inside City Limits 1 No otry?
	1 ☐ Never Married	/as Decedent Ever in U.S. med Forces? Yes 22 No Yes, Give		Hispanic Origin? (Specifican, Mexican, Puerto Ric		14. Race - Americ Black, White,	etc.
15-0 72 h 72 h 72 h 72 h	3 Widowed 4 Divorced Y. 15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	ear or Dates: n pleted) otlede (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire			Specify: Black	dustry
be file oth oth oth oth oth oth	17. Father's Name (First, Middle, Last)	· K	oc fer	18. Mother's Name (F	irst, Middle, Maide		-ow hy
6 e a a a	19a. Informant's Name/Relationship. (Type, P	20b. Place of	Mailing Address (Stree 35 C. P Disposition (Name of y, crematory or other pla	2403 SHI	IRLEY AVE 20c. L	BALTO, MD. 21	215 wn, State
Baltimore, N pernit. Pages 1 and 1 Department of Health Important: If Item 27 any injury or other tr	1 Burial 2 Sremation 3 Remov 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Grean o	uccat Come	ess of Facility (1/19)	Youar -1	Sport K	Norghow
Physician /Medical Examiner	23a. Part. Enter the disease, or complication	ns that caused the death. Do nuse on each line. Subarcach Due to (or as a consequence of	not enter the mode of dy	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
760, te be executed system and the burial-transit cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of					
I Records, P.O. Box 687(The law requires that the death certificate to cate has been signed by the attending physic page 2 should be detached for use as the Completed by Physician/Medica	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □Pregnant at time of death □ Unknown	3 Ectopic pregnand 5 Other (specify)	y		23d. Date of delive Month	ory Day Year
cords, P	Part II. Other significant conditions contribut hypertension	ting to death but not resulting in	the underlying cause gi	ven in Part I.		use contribute to th	2 /
Vital Rec	25. Was case referred to medical			26. Place of Death (C	24a. Was an autopsy performed? 1 Yes 2 No. Check only one)	death?	osy findings available inpletion of cause of
on of ding Phys	2 Accident investigation	a. Date of Injury 2 LER/Ou	ime of 28c. Injury Wo	rk?]Yes 2 □No	l. Describe how inju	ny occurred	
Division To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat	(Check only 2 Medical Examiner: C	n: To the best of my knowledge On the basis of examination and and manner stated.	, death occurred at the to	me, date and place, and opinion, death occurred	due to the cause(s at the time, date an	s) and manner as st d place, and due to	ated. the cause(s)
To the within To the company	29b. Signature and title of certifier Marchaela 30. Name and address of person who comptes	led cause of death /Ham 2201		spital of	4	ucky 2	
State Registrar	Mariya F. Dar 31. Date filed (Month, Day, Year)		Sinai Vo	spital of	Balt	imore	

			1 - State Registrar		epartment of Health and Certificate of Death		giene Reg. No. 200	4 02625
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Florene Gail O'Dea 4a. Facility Name (If not institution, give street and number) ARRIVED HEALT CARE		4b. City, Town, or Location of Dea	2. Date of Dea Month	Day Year	3. Time of Death 5:10 A M
r,	Funeral Director		5. Social Security Number 212–36–0094 Usual Residence of Decedent	last birthd Yrs	Months Days Hours Mir		(, Year) C	thplace (State or Foreign buntry) Virginia
	se Maryland 8a-f show	Director	10a. State 10b. County 10c. City Maryland Baltimore	y, Town o	Baltimore			10d. Inside City Limits
	ath with the 23s or 2 ust be n	ral Dire	10e. Street and Number 1717 Willis Drive		10f. Zip Code 21227		10g. Citizen of What Co United	States
980	s i and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exposited cust be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes ZY No If Yes, Give Year or Dates:	.S. 1	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 \(\bar{X}\)No Specify:	Specify Yes or No- rto Rican, etc.)		
1215-0	within 72 ho iene. • than "natu ine Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	(G lif	ecedent's Usual Occupation Give kind of work done during most of wi fe. DO NOT use retired) HOMEMA KET	orking	16b. Kind of Business	
yland 2	should be filed and Mental Hygi s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Chesley K. Simmons		18. Mother's Na	ame (First, Middle, sther Mae	Maiden Sumame) Nelson	wn Home
re, Mar	es 1 and 2 shoof Health and 7 item 27 is m r other traum		19a. Informant's Name/Relationship (Type, Print) Thomas O Dea / Husband 20a. Method of Disposition 20b. P	171	Mailing Address (Street and Number or F 17 Willis Drive, Ba isposition (Name of crematory or other place)	altimore,		21227
Baltimore, Maryland 21215-0036	permit. Pages 1 Department of H Important: If ite any injury or ot		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ENTOMO. 21. Signature of Funeral Service Licenses.	udon	Park Mausoleum 2/2 22. Name and Address of Facility Hu	ıbbard Fu	Baltimore, neral Home	Inc.
	Physician /Medical Examiner		23a. Part 1. Enter the disease of complications that caused the deeth shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	h. Do not lial	infarction			Approximate Interval Between Onset and Death
,190,		I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Use to (or as a consequence of the conseque					
0. Box 687	2 2 2	Physician/Medical	d	I death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	ivery Day Year
UTEY rds, P.	v requires that the been signed by should be detac	٦	Part II. Other significant conditions contributing to death but not resu	ulting in the	ne underlying cause given in Part I.		bacco use contribute to	o the cause of death?
(C) OC		Completed				24a. Was a autops perform	med? prior to death?	utopsy findings available completion of cause of 2 No
Jea Ion of Vital	hysi his c	atlon; To Be	25. Was case referred to medical examiner? Yes 2 No	ER/Outpa 28b. Time Injur	atient 3 DOA Other: 4 Nursing		ence 6 Other (Specow injury occurred	cify)
	itel or Attending is after death. el Director: After led in by the funer	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	y) 		City or Town		
*	To the Hospitel or A within 24 hours after To the Funerel Director Completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Exeminer: On the basis of examinat and manner stated.	wledge, de tion and/o	or investigation, in my opinion, death occ	e, and due to the courred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	1	2	29b. Signature and title of certifier M		DY7353	-	January 29	20014
	6		30. Name and address of person who completed cause of death (Item Ton Falck MD 5+ Agres MD 51. 31. Date filed (Month, Day, Year) 32. Registrar's Signal FEB 0 2 2004	23a) (Typ	900 Cuton Avenue	Baltomor	e, Manyland	1 21229
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signal FFB 0 2 2004	ture	freels			

	MCIA O		For State Ragistrar	State	of Maryla	nd / Depa <i>Cei</i>	artment <i>tificate</i>	of Health of Deat	and M h		giene Reg. No.	2001	02626
			Decedent's Name (First, Middle, La	ist)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia		PATRICIA	OWEN	S					Januar	y 25	, 2004	21:10 M
	/Medic Examin		4e. Fecility Name (If not institution, gir	ve street and n	umber)		4b. City, T	own, or Location	on of Death		4c. (County of Deet	h
		4	Maryland Genera	l Hospi	tal			Balti				N/A	
12	Funeral			Sex	7. Age (In yrs	s. last birthday)	If Under 1 Months	Days Hour	ter 24 Hrs. s Min.	8. Date of Birt (Month, Da	h y, Ye <i>ar</i>)	9. Birt	hplace (State or Foreign untry)
	Director		212-60-9077	1□M 2 [×] E ¹ ¥F	5	3 Yrs.				FEB 13			ARYLAND
	p.	-	Usuel Residence of Decedent 10a. State 10b. County		100.0	City, Town or Lo	cation						10d. Inside City Limits
	arylar ehov	_	10a. State 10b. County		100.0	nty, Town of Co	Cation						1 X Yes 2 □ No
	8a-f	cto	MARYLAND N/A			BAI	TIMOR				10- Citi-	of \4/b of Co	
	or 2	Director	10e. Street and Number				10f. Zip (en of What Co	untry :
	ath v	ra	504 GOLD STRE			11.0	Man Daniel	21217 ent of Hispanic	Origin? (Co.	oity Voc or No		S.A.	ocan Indian
	er de	Funeral	11. Marital Status	Armed F	cedent Ever in forces? 2 XNo	0.5.	Yes, speci	ty Cuban, Mexi	can, Puerto	Rican, etc.)		Black, Whit	
9	s aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	If Yes, G	ive		1□Yes 2	No Spec	ify:			Specify: BI	LACK
3	hour		15. Decedent's E					Occupation			16b. Kin	nd of Business	Industry
5	in 72	Completed	(Specify only highest gi	rade completed		(Give	kind of world	k done during m e retired)	nost of worki	ng			
7	iene.	mo	Elementary/Secondary (0-12) 11th grade	College	(1-4or 5+)	ACC	COUNTA	NT			MD	STATE (SOVERNMENT
2	be filed within 72 hours after death with the Maryland lat Myglene. Its Myglene do the than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Exacitation and be notified at	Be C	17. Father's Name (First, Middle, Las	t)				18. Mo	other's Name	(First, Middle,	Maiden :	Sumame)	
and	Hd be lenta ked ked	To B	JOHN E DORSE	Y					NELLI	E CECEL	IA T	HOMAS	
E Y	shou nd M mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street and Nur	mber or Rura	I Route Numbe	er, City or	Town, State, a	Zip Code)
Ž	nd 2 alth a 27 ls		Catherine Owens	/Daught	er	2455	5 DRui	d Hill	Avenu	e, Balt	imor	e, Mary	land 21217
กั	s 1 a f Hei item othe		20a. Method of Disposition		20b	Place of Dispo	sition (Nam	e of		ate		cation - City or	
Ē	Page ent o nt: If ry or		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			IEW CATE	-	, , , , ,	01-3	0-04	BAT.	TIMORE.	MARYLAND
Baitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 53a or 28a-1 ahow sny injury or other traumatic event, in a Medical Examination must be notified at ange.		21. Signature of Foneral Service Lice	ensee /	1	22	2. Name and	Address of Fa	cility	*			
ñ	Depar Depar Impo sny ir		(haree	A. W	owel	0		M C BRO NORTH			F'UN	ERAL HO	OME P.A.
1		ž.	23a. Part1. Enter the disease, or con shock, or heart failure. List on	mplications that	caused the de						rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final			. Best seed	7_				p.:		Onset and Death
	/Medical		disease or condition resulting in death)		censive (or as a cons		LOSCIE	rotic C	aroro	vascula	r_Dr	sease_	
	Examiner			b									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury		o (or as a cons	equence of):							
	cuted	Examiner	that initiated events	C									
Ď.	en ar rial-t	Ex	resulting in death) Last	Due to	o (or as a cons	equence of):							
04/8	the death certificate be executed y the attending physicien and iched for use as the buriat-transit	dicai	•	d									
٥	ntifica ng ph as th	0	IF FEMALE:					·					
X R R	eath certific attending p	an/l	23b. Was decedent pregnant		utcome of preg		Ectopic pre	egnancy			2	3d. Date of de Month	livery Day Year
	be at be at	sici	in the past 12 months?	4□Pre 9□ Uni	gnant at time of	death 5	Other (spe	ecify)	*			14107141	Ju, 100.
J.	at the	Physician/M	9 Denknown		4 1 b - 1 4 4 4					220 Did t	obagge III	an anatributa t	the cause of death?
	The law requires that the de ste has been signed by the a bage 2 should be detached f	by	Part II. Dther significent conditions	contributing to	death but not r	esulting in the L	inderlying ca	ause given in Pa	art I.		Yes 2		robably 4 Unknown
Hecords	w require been sis	ted	1731111114							,,,	195 2	740 201	COADIY 4 DIKITOWII
ပ္	law ras be	pie	OBESITY							24a. Was auto	osy	prior to	topsy findings available completion of cause of
Y		Completed								1 Yes	rmed? 2X No	death? 1 ☐ Yes	250 No
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						lace of Deat	(Check only o	one)		
0	Physician: r this certific ral director,	2	1X Yes 2 No			XER/Outpatie				me 5 Resi			city)
2	ding P h. After t funera	on:	27. Manner of Death 1X Natural 5 Pending	28a. Dat (Mo	te of Injury onth, Day Year)	28b. Time o		Bc. Injury at Work?		28d. Describe	now injury	y occurred	
<u> </u>	uttendii death. ctor: A y the fu	cati	2 Accident investigate 3 Suicide 6 Could not	he			М	1 Yes 2		201 1	04	411	-10-114
DIVISION	or Att	Certification:	4 Homicide determine	d ∠89. Pla	ce of Injury - At Iding, etc. <i>(Spe</i>	t home, farm, st <i>icify)</i>	reet, factory	, office		City or To			ural Route Number,
	urs al												
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifying I (Check only one)	aminer: On the	basis of exami								
	thin 2 the mple	Med	29b. Signature and Hitle of certifier	and ma	anner stated.		290	. License numb	oer		29d. Date	e signed (Mon	h, Day, Year)
r	T w		1 00/	11	-								
	0		7 /001	1/1/	Ta	10m 22=1 =	Drie*	0.C.	тт. С.		O GITH	uary 26	2004
	0		30. Name and address of person wh		iuse oi geath (l			treet,	Raltin	morre M	arvl	and 212	vn1
	Sta	ato	31. Date filed (Month, Day, Year)		, Registrar's Sig	nature			-ALL LIL	wie, n	ىد ىر عى	WAL 616	· V I
· 60	Regist		EER A 2		Districte o	12 1	TOTAL S						

			1 - For State Registrar		-	partment of ertificate o			Reg. No. 2	14.02627
В	Physici	an	1. Decedent's Name (First, Middle,					2. Date of De Month	Day Y	ear // : co P M
	/Medic Examir		4a. Facility Name (If not institution,		·)	4b. City, Town	n, or Location of	of Death	2.9/20 4c. County of	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
	Exami		GOOD SAMA	RMAN H	OSPITAL		ACTIM			LTIMORE
	Funeral Director		430-20-2194	6. Sex 7. A	ge (In yrs. last birthda 81 Yrs.	Months Day		24 Hrs. 8. Date of Bir Min. (Month, Da July 2	th 12, 1922	B. Birthplace (State or Foreign Country) Texas
	and and		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary R-f sh	żor	Maryland n	/a		Baltimo	re			1XXves 2 □ No
	h with the 23a or 28a st be not	al Director	10e. Street and Number 5028 Frankford	d Avenue		10f. Zip Code	2120	06	10g. Citizen of Wh	at Country? I States
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, I'm Medical Exartinetrast be inclined at once.	Completed by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Amed Forces' d 1 M Yes 2 If Yes, Give Year or Dates:	No			gin? (Specify Yes or No n, Puerto Rican, etc.) Mexican	}	American Indian, White, etc. White
21215-0036	within 72 ho one. Ihan "natu ie Medical	mpletec	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Giv	edent's Usual Occ re kind of work doi DO NOT use ret Designer	ne during most tired)	t of working	16b. Kind of Busin	
N	filed y Hygie Other I	ပိ	12 yrs. 17. Father's Name (First, Middle, L	ast)		Designer		er's Name (First, Middle,	1	J11043C
Maryland	should be t and Mental I s marked of umatic eve	To B	George Orti:	Z			Cor	nsuela	Diaz	
Aan	2 sho and 1 is ma reuma		19a. Informant's Name/Relationshi			-		er or Rural Route Numb		
	1 and Health tem 27		Mrs. Frances Or	LIZ	20b. Place of Disposer cometery, cr	28 Frank		Venue Dai	timore, N	
ē	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.	3 □Removal from State ecity) Fntombment.				Feb. 2,2004		more, MD
Baltimore,	permit. Departm Importe any inju		21. Signature of Funeral Service L			22. Name and Add	dress of Facilit	у		ford Road
			23a. Part1. Enter the disease, of shock, or heart failure. List o	omplications that cause nly one cause on each	d the death. Do not e	nter the mode of d	tying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between
7	Prysician		Immediate Cause (Final disease or condition resulting in death)	a	SEPSIS					Onset and Death
1	/Medical Examiner		rossiang in dozini)		s a consequence of):	ARCIT	100	A		
L		ē	Sequentially list conditions, if any, leading to immediate cause. Enter undanying Cause (Disease or injury	b. —	s a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.1	<u></u>		
	tate be executed shysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	s a consequence of):					
8760,	s be ey sician buria	ical E		340 (0, 45	a consoquence on.					
687	tificate ng phy: as the			d.						
O. Box	or Attending Physician: The law requires that the death certificate be executed that death. Or that death cardificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit or by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnar □ Other (specify)			23d. Date of Month	
, P.O.	res that t igned by be detar	by Ph	Part II. Other significant condition	s contributing to death i	but not resulting in the	underlying cause	given in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
ords	w require been sig should b	ted t	HEPAT	DENCE	PHALOI	PATHY		11	res 2□No 3	Probably 4 □Unknown
of Vital Records,	The law re ate has be bage 2 sho	Completed							prio rmed? prio	re autopsy findings available r to completion of cause of th?
/ita	ysician: The is certificate hi director, page	Be C	25. Was case referred to medical examiner?					of Death (Check only o		
d	Physic this cral dire	<u>٩</u>	1 Yes No	Hospital: Inpati		ant 3 DOM		rsing Home 5 Resid	dence 6 Other ((Specify)
no.	ading l tth. :: After e funer	tion	1 ■ Natural 5 ■ Pending 2 ■ Accident investiga		ay Year) Injury		njury at Vork? □Yes 2 □1		iow injury coodined	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of In	ijury - At home, farm, s tc. (Specify)	treet, factory, offic	ce	28f. Location (S City or Tov		or Rural Route Number,
	ne Hospit 24 hours ne Funere pletely fille	Medical (29a. Certifier (Check only one) Certifying	Physician: To the best xaminer: On the basis of and manner st	of examination and/or i	ath occurred at the nvestigation, in my	time, date and y opinion, deat	d place, and due to the th occurred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date signed (A	Month, Day, Year)
			Selhana	, MD	17.00	DO	0 60 6	08 +	01/2	4/2004
4	/		30. Name and address of person w	no completed cause of a	death (Item 23a) (Type	o, Print)	SAI	MARITA	N HO	Month, Day, Year) 9/2004 SSP17AL
	Sta		31. Date filed (Month Day, Year)	32. Redikt	rar's Signature	books	-	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Registr	ar	FEB 0	2 2004	The state of the s		9_			

			1 - State Registrar	State of Ma	ryland		artment of H tificate of t		nd Me		giene Reg. No. 2	004	02628
			1. Decedent's Name (First, Middle, Last)						2. Date of De		Yeer	3. Time of Death
	Physici /Medic		ITALIA PAS	SSERI					J	ANUAF	RY BO.		4 5:00 AM
	Examin		4a. Facility Name (If not institution, give Saint Joseph	street and number) Medical	Cen	ter	4b. City, Town, or	0.0000	Death OWSO	n	4c. Cou	inty of Deati Bal	timore
	Funeral Director		5. Social Security Number 6. Se 203-01-4439	x 7. Age	(In yrs. la 88	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	3. Date of Bir (Month, Da 2/23/1	y, Year) 9 1 5	9. Birth Cou ITA	nplace (State or Foreign untry) LY
	pug *		Usuel Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation						10d. Inside City Limits
	Manyla f sho	5	MD BALTIM	ORE		OWSON							1 ☐ Yes 2 【XNo
	with the I a or 28a- Lbe rolli	Director	10e. Sireel and Number 800 SOUTHERLY RO				10f. Zip Code 2128	 6			10g. Cilizen		untry?
KO.	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, Ita Medical Examinat must be notified at	Funeral	11. Marital Slatus 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 [3]N		1	Was Decedent of Hi f Yes, specify Cuba	n, Mexican,	in? (Spec Puerto R	ify Yes or No ican, etc.)		Race - Amer Black, White	
003	hours a	9	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:			Yes 2 No	Specify:					ITE
7	in 72 in "nat	Completed	15. Decedent's Edu (Specify only highest grad	le completed)		(Give	lent's Usual Occupa kind of work done o DO NOT use retired	ation du <i>ring</i> most (f)	of working	7	16b. Kind o	f Business/I	ndustry
212	d with giene.	mo	Elementary/Secondary (0-12) 12th GRADE	College (1-4or 5-	-)	HOME	MAKER				OWN	HOME	
Maryland 21215-0036	ild be filed lental Hygis ked other ic event, II	To Be C	17. Father's Name (First, Middle, Last) MARIO MARIOTTI							First, Middle,		name)	
Mary	and 2 should balth and Men n 27 is marke ler traumatic		19a. Informant's Name/Relationship (T)	rpe, Print) SON			g Address (Street a			Route Numbe			ip Code) 1057
more,	Pages 1 ar		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ f 1 □ Donation 5 □ Other (Specify)		cer	metery, cren	sition (Name of natory or other plac		Da 2/2/2		20c. Location	on - City or I	
Baltin	permit. Pages Department of I Important: If ite any injury or of once.	1	21. Signature of Funeral Service Licens		, were	22		s of Facility	THE	JOHNS	ON FU	VERAL	HOME, P.A.
			23a Part 1. Enter the disease, or comp	lications that caused	the death.							2 12	Approximate
,	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS									Interval Between Onset and Death DAYS
	/Medical Examiner		AND A SANDAR AND A SANDAR AND AND A SANDAR A	Due to (or as a URINAF			INFECTI	ON					DAYS
	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	ence of):							
8760,	icate be executed physician and s the burial-transit	dical Exar		Due to (or as a	conseque	ence of):							
9	tificate ig phys as the	ledic		d						Yes			15000m
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal	death 3	Ectopic pregnancy Other (specify)					Date of delive Month	r ery Day Year
٥	res that the de igned by the a be detached f	by Ph	Part II. Other significant conditions co	ntributing to death bu	t not result	ting in the ur	iderlying cause give	en in Part I.		23e. Did to	obacco use c	ontribute to	the cause of death?
ord	w require been signation	eted	RENAL_INSUF	FICIENCY_						1 🗆 \			bably 4 Unknown
Vital Records,		Completed		***					_	24a. Was autop perfo 1 Yes	an 24 sy med? 2)27 No	b. Were aut prior to o death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of 2D No
Vita Vita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	a.c.		Check only o			
o	Phys	٠ <u>۲</u>	1 Yes 2 No	1 Al Inpatier		R/Outpatien 28b. Time of		4 14013		d. Describe t			îfy)
0	nding th. : After e fune	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	28c. Injury Work	(? Yes 2 □ N	i	o. 50001150 1	ion injury co	341100	
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - Al hom (Specify)	ne, farm, str	eet, factory, office		28	f. Location (5 City or Tox	Street and Nu m, State)	mber or Rur	al Route Number,
	To the Hospital or A within 24 hours after to the Funeral Directompletely filled in by	edical C	29a. Certifier 1 (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best o	examination	rledge, death on and/or inv	occurred at the time restigation, in my op	ne, date and pinion, death	place, an	d due to the	cause(s) and date and plac	manner as	stated. to the cause(s)
	Fo the	Me	29b. Signature and title of certifier				29c. License	number			29d. Date sig	ned (Month	Day, Year)
	5		1 Lading	M-ella	M.O		D 4	1410		1	onwar	7 3014	, 2001 .
	X		30. Name and address of person who c	ompleted cause of de	ath (Item 2	23а) (Туре,	Print)					1	
		•	JOGINDER MEHTE 31. Date filed (Month, Day, Year)	32. Registra	1211 (OSLER	DRIVE	TOWSC	IM MC	ARYLA	ND 21	204	-
	Sta Registr		FFB 0 2 2	₩.	ر دری		Sack)						

т.1		•	1 = For State Registrar	State of Marylan		artment of F			giene , Reg. No. ⁽	2004	02629
	Physici		1. Decedent's Name (First, Middle, Last Patricia Picket					2. Date of De Month JANUAI	Day	, 2004	3. Time of Death 5:23 P M
**	/Medio		4a. Fecility Name (If not institution, give 2611 E. FAIRMOUNT	AVE		BALTIM	Location of Deat	h	4c. C	County of Death	
\$	Funeral Director		5. Social Security Number 6. Se 219-58-3670 10 Usual Residence of Decedent	7. Age (In yrs.	last birthday Yrs.	Months Days	if Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da Feb 17	y, Year) 195	9. Birthp Coun	lece (State or Foreign try) unk
	deeth with the Maryland rms 23a or 28e-f show	tor	10a. State 10b. County MD	10c. Cit	y, Town or L Bal	ocation timore				1	0d. Inside City Limits 1∑ Yes 2 ☐ No
	eth with the Marylan s 23a or 28e-f show wat be nutified at	ai Director	10e. Street and Number 2611 E. Fairmo unk			10f. Zip Code	21224		10g. Citize USA	en of What Coun	try?
	n 72 hours after dee "natural", or Items golical Exercit et a	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	.s. 13. unk	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛱 No	ispanic Origin? (S in, Mexican, Puer Specify:	to Rican, etc.)		4. Race - Americ Black, White, Specify:	black
-¢121	than the	Completed	15. Decedent's Edi (Specify only highest grad unit (0-12) u	ucation de completed) nk College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of wo	unk. rking	16b. Kind	d of Business/Inc	dustry UNK
<u> </u>	be file of othe event,	To Be Co	17. Father's Name (First, Middle, Last)			unk	18. Mother's Na	me (First, Middle	Maiden S	Gumame)	unk
Mar	s 1 and 2 should 4 Health and Men 1tem 27 Is marke other treumatic		19a. Informant's Name/Relationship (T)		111	Penn Street		imore, M	D 21	201	·
baltimore,	permit. Pages 1 Department of Hi Importent: If iter any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	emetery, cre	osition (Name of matory or other plac		Date		ation - City or To	
g C	Departing Departing Important in Suny in Sunce.		21. Supported to the paral Saprice dicent	Malle	В	tate Andri altimore,	MD 2120	01		imore S	Approximate
4	requires that the death certificate be executed Wedical Wedical Fraction and provided by the attending physician and hould be detached for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hypertensive Due to (or as a conseq b. Due to (or as a conseq c. Due to (or as a conseq d	e Arte uence of): uence of):					isease	Interval Between Onset and Death
O. Box 6	the death certific y the attending p iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify)			23	3d. Date of delive Month	ry Day Year
cords, P	w requires that the dea been signed by the a should be detached fo	by	Part II. Other significent conditions co	ntributing to death but not res	ulting in the I	underlying cause give	en in Part I.			e contribute to th	e cause of death? ably 4 Munknown
Hec	The law ate has t page 2 s	Completed						24a. Was autor perfo 1 \(\text{Yes}		24b. Were autop prior to con death? 1 \(\text{Yes}	osy findings available inpletion of cause of 2 No
Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Oth		ath <i>(Check only c</i> Iome 5 ☐ Resid		Other (Specify	SCENE
ion of	ding P. Afte fune	ation: T	27. Manner of Death 1 反 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	Worl	at at	28d. Describe I			SCHUL
DIVISION	or A after Dire in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, si	reet, factory, office		28f. Location (: City or Tox	Street and vn, State)	Number or Rura	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☑ Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the tin nvestigation, in my o	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) a date and p	nd manner as sta place, and due to	ated. the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier 20Lulu	OCAC,		29c. Licenso	number M E			signed (Month, L	
			30. Name and address of person who c		n 23a) (Type		nn Stree	t, Balti	more,	, Maryla	nd 212 0 1
F.	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 2 2004	32. Registrar's Signa		M.					
DHN	MH 17 Rev 1/2	001	- LOU D D 2001	A CONTRACTOR OF THE PARTY OF TH	A STATE OF THE PARTY OF THE PAR						

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Maryla		artment of H rtificate of L			giene Reg. No. 200	4 02630
			Decedent's Name (First, Middle, La	st)				2. Date of Dea		3. Time of Death
	Physicia	_	Arnold August Joh	n Rausenberge	er			JAMICIAN	Day Year 4 28 20	. 0 M
	/Medic Examin	aı -	4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death		4c. County of De	
	_ Xuiiiii	•	ST ACHES H	EACTHCARE		BACTIM	IORE		n/a	
75. ₃ 5	Funeral		5. Social Security Number 6. S	Sex 7. Age (In y	rs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h 9. 8	irthplace (State or Foreign Country)
	Director		219-32-9840	IXM 2□F 66	6 Yrs.	Month's Days	TIOUTS IVIII.			aryland
**	D.		Usual Residence of Decedent	140-	C1 - T					
	rytar	_	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	e Ma	8	Maryland n/a	P	Baltimor	e				1√2 Yes 2 □ No
	or 28	- Le	10e. Street and Number	3		10f. Zip Code			10g. Citizen of What	
	th wi	<u>e</u>	5148 Stafford Road	1 		21229			United S	
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-f show int, the Medical Evanance must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Styles 2 in No Hiftes, Give Year or Dates:	n U.S. 13.	Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify: W	
7	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	edent's Usual Occupa a kind of work done of DO NOT use retired,	ation	dina .	16b. Kind of Busines	s/Industry
Ž	hin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,)	Wing	unisex h	air salon
7	filed within Hygiene. other than	5	12	0	hair	dresser				
B	m - 0 5	e	17. Father's Name (First, Middle, Last			and the state of t	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
Maryland		၉	Arnold Joseph P. 1	Rausenberger			Elsie A	ugusta 1	Mattheiss	
a	and !		19a. Informant's Name/Relationship	** .					er, City or Town, State	
Σ	and 2 salth n 27 i		Julie Grove - sis							, MD 20866
ore O	of He fiten		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □		 Place of Disp cemetery, cre 	osition (Name of ematory or other place	θ)	Date	20c. Location - City	or Town, State
Ĕ	Pagnent nent ant: h		`4 □Donation 5 □Other (Speci		ayview	Crematory,	Inc. $1/2$	9/04	Baltimore	, Maryland
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer importent: If frem 27 is mark any injury or other traumatic once.		21. Signature : Funeral Servic (Lice	Z NK					neral Home	
	*		23a. Part1. Enter the disease or con shock, or heart failure. List only	plications that caused the d	death. Do not er	IU / WILKER	IS AVENUE g, such as cardiac	or respiratory ar	more, Mary	land 21229 Approximate
	Physician		Immediate Cause (Final disease or condition		YLDEXE		ien monif			Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a con						
2000 Fr.	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con	sequence of).					
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):					
58760,	siciar buri			4						
287	ficate physis the	edical		0.						
Box	leath certific attending p	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		_			23d. Date of d	elivery
m	attel attel	Physician/M	in the past 12 months?	1□Live birth 2□f 4□Pregnant at time		□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
<u>Р</u> О	res that the de signed by the a be detached f	ıysi	9 Unknown	9□ Unknown		·				
ב	that led b deta	F P	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
gp	uires I sigr Id be	d by	ACUTE REN	IAL FAILURE	conf. color pone			101	/es 2 □ No 3 □	Probably 4 Dunknown
Ö	w require been sig should t	lete						24a. Was	an 24b Were	autopsy findings available
Äė.	has has ge 2	Completed	INFLUENZ	71				autop perfo	rmed? prior t	completion of cause of
a	n: Ti ficate r. pa		OF Man area referred to medical	1			00 Di4 D			es 2 No
5	ding Physician: The th. h. After this certificate ha funeral director, page	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	a C EB/Outcotic	Othe	26. Place of Deal		<i>ne)</i> dence 6 ∐Other (Si	
o	Phy rald	5	27. Manner of Death	28a. Date of Injury	28b. Time				now injury occurred	oecny)
on	ding h. Afte fune	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury		(? Yes 2 □No			
Division of Vital Records,	deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not I	De Place of Injuny	At home, farm, s	treet, factory, office		28f. Location (S	Street and Number or	Rural Route Number,
<u>S</u>	after Dire	Certification:	4 Homicide	building, etc. (Sp		,,		City or Tou	vn, State)	
_	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use as	Medical C		hysician: To the best of my miner: On the basis of exam						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed (Mo	nth, Day, Year)
)	1.		+ Faw	MD		P156	24		JAHUARY :	28 2004
	XX,		30. Name and address of person who	completed cause of death	(Item 23a) (Type			1 400	111100	-3 200 T
)		LAWNENCE OS	F 900	CATOH	AVE NUT	= 13 AU	MIGNE	MD. 2	229
	Sta	te	31. Date filed (Month, Day, Year)	32. Registre's S		1 6			1 - 1	
	Regist	ar	FFR (2 2004 > 2	Aller of the	A DESCRIPTION OF THE PARTY OF T				

		1	For State Registrar	State of Mar	_	partmer Pertificat				Reg. No	2001	02632
/	nysicia Medica xamine	n al	1. Decedent's Name (First, Middle, Las ARS & NI O 4a. Facility Name (If not institution, give	11cheile	Roman	4b. Çity,	, Town, or	Location of D	2. Date of D Month JANU	1ry Da	24, 20, c. County of Dec	
Fui	neral ector		211 82 8724		(In yrs. last birtho	Months	r 1 Year Days	MURE If Under 24 H Hours N	Hrs. 8. Date of E (Month, I OCHIBER.	Birth Day, Year,	N A 9. Bi	rthplace (State or Foreign ountry)
Maryland	iled at		Usual Residence of Decedent 10a. State 10b. County M.D. NA		BA HIMIR							10d. Inside City Limits
ath with the	ust be not	rai Dire	10e. Street and Number 4801 Chowson 54			2	Code			4	itizen of What C	
72 hours after death with the Maryland	Exp. diner.c.	by Funeral Director	11. Marital Status Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 ☐ Yes	cify Cuba	ispanic Origin? in, Mexican, Pi Specify:	? (Specify Yes or 1 uerto Rican, etc.)	No-	14. Race - Am Black, Wh Specify: B	ite, etc.
d within 72 hours all giene.	ne Medical	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)) (G		ial Occupionk done duse retired	during most of ()	working		Kind of Business	s/industry
id 2 should be filed vith and Mental Hygie	tic event,	To Be Co	17. Father's Name (First, Middle, Last) Gronge Hope		<i>y</i> C,	, acomo	230	18. Mother's	Name (First, Midd	lle, Maidei		
E, INICI Y 1 and 2 should be atth and N	Ottent; I for it is named to other the Madical Exp. inter rount be notified at a.		19a. Informant's Name/Relationship (CERalding Rauren 20a. Method of Disposition		2605 20b. Place of D	Rus Co	umbe		Rural Route Num		or Town, State,	
permit. Pages 1 a	any injury or of		1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer	y)	anmoton:	HMe 1 22. Name a	other plac	ss of Facility	Beils F	Buner	at Hor	
Exam	dical dical name of partial strangers of partial st	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a	SEPS I consequence of) consequence of) consequence of)	S MIC !			diac or respiratory	arrest,		Approximate Interval Between Onset and Death A clays Says
. 0	led by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1☐Live birth 2 4☐Pregnant at ti 9☐ Unknown	☐ Fetal death	3 □Ectopic p 5 □ Other (s				AAA	23d. Date of do Month	əlivery Day Year
ords, r.O	p eq	by	Part II. Other significant conditions of	contributing to death but		he underlying	cause giv	en in Part I.		d tobacco □ Yes 2		to the cause of death? Probably 4 □Unknown
The law	page 2 should	Completed	AIDS						_ 24a. W au pe 1 ☐ Yes	topsy rformed?	_ death?	
OI VILA Physician:	director,	To Be (25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital:	t 2□ER/Outp	atient 3□ D	OA Oth	05	Death <i>(Check onli</i> ng Home 5 ☐ Re		6 □Other (Sp	ecify)
ath.	or: Arren	Certification:	27. Manner of Death 1	e Jan Blace of Injur	y - At home, farm	М		yat k? Yes 2⊡No	28f. Location		ury occurred and Number or F te)	Rural Route Number,
• Respitai or 124 hours after	to the Funeral Directo	Medical C		nysician: To the best of miner: On the basis of e and manner state	xamination and/							
To the within 2	comp	Me	29b. Signature and title of certifier	Stryn 			Rey			i	ate signed (Mor	-
	Sta	te	30. Name and address of person who ZEEDA MATNE 31. Date filed (Month, Day, Year)		ath (Item 23a) (Ty Signature	Print)	Bluc	1. Bal	timore	MI	212	28,2004 39

Roman

Arsonia

Physician Southern Prist Missin Lab Southern Prist Missin Lab Southern Prist Missin Prist			d	State of Maryland / Depa	rtment of Health and N tificate of Death	ental Hygie Reg.		E,
Exchinery Fig. 12 April 12 Ap	6					2. Date of Death	3. Time of Death	
POTENTIAL PARTY NAMED TO BE SET THE PROPERTY OF THE PARTY NAMED TO BE SET THE PARTY NAMED TO BE		•		Esther P. Razzano		January		A
Support Director Director Di					4b. City, Town, or Location of Death		4c. County of Death	
The control of the		L.XGITIII		900 Union Church Road	Elkton		Cecil	
Description of the property of	48	Funeral	*			(Month, Day, Ye	ear) 9. Birthplace (State or Foreig	n
The control of the				141-12-5768 1 M 3CXF 80 Yrs.	Mortalia Days	May 29, 1	923 New Jersey	_
Beautiful to Continue Part		D >			cation		10d. Inside City Limits	5
Beautiful to Continue Part		anyla ehov	5		outron.		1 □ Yes 2,□,No	0
Beautiful to Continue Part		Ne M	ecto		10f Zin Code	10a		
Beautiful to Continue Part		with t	급					
Beautiful to Continue Part		eath	eral	11 Marital Status 12. Was Decedent Ever in U.S. 13. \	Was Decedent of Hispanic Origin? (St	pecify Yes or No-	14. Race - American Indian,	
Beautiful to Continue Part		ter d	In I	Armed Forces?	f Yes, specify Cuban, Mexican, Puero	Rican, etc.)		
Beautiful to Continue Part	2	urs a	by	If Yes, Give	1 ∐ Yes 2 M No Specify:		Specify: White	
Beautiful to Continue Part	5	2 ho	ted		dent's Usual Occupation	kina 16	b. Kind of Business/Industry	
Physician (Medical Examiner) Physic	<u>'</u>	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		A	
Physician (Medical Examiner) Physic	N	ed wi	Co	,,		- (Fina Adidala Ada		_
Physician (Medical Examiner) Physic		d offi	Be				iden Sumame)	
Physician (Medical Examiner) Physic	<u>X</u>	ould Men Parke	မ				Situar Town State Zin Code	_
Physician (Medical Examiner) Physic		12 sh h and 7 Is n Iraun						
Physician (Medical Examiner) Physic	.	1 and Healt em 2 ther		20b. Place of Disposition	sition (Name of			
Physician (Medical Examiner) Physic	בַ	nt of in or or or or or or or or or or or or or		1 Burial 2 XI Cremation 3 Removal from State		3/2004	Camdon NT	
Physician (Medical Examiner) Physic		iit. Partme artme ortani injury						
Physician Medical Examiner: Physician Medical Examiners Physician Physician Medical Examiners Physician	g	Deport Impo		History of Chrodie	111 S. Queen Stre	. Foara F Let, Risin	ig Sun, MD 21911	
Physician (Medical Examiner) The property of the property of	I			23a Part 1. Enter the disease, or complications that caused the death. Do not ent			Approximate Interval Between	
Sequentially list conditions. If any, leading to immediate programs as a consequence of): Sequentially list conditions. If any, leading to immediate programs as a consequence of):		Physician		Immediate Cause (Final disease or condition	- B cell		445	
State State Sequentially list conditions, if any, leading to immediate in westigation Jour to (or as a consequence of): Jue to (or as a co				resulting in death) Due to (or as a consequence of):	14 A			
Company of the property of the	Ŋ.	LAdminer	-	Sequentially list conditions, b. Due to (or as a consequence of):	Mass	7		
Section 1985		led sit	nine	cause. Enter Underlying Cause (Disease or injury	o Dispos	()_0_		
Section 1985		and and al-tra	xar		2 5000			
9 Unknown School State	760	ysicia e buri		d				
9 Unknown School State	9	tificat 19 ph) as th						
9 Unknown School State	ŏ	endir r use	an/N	23b. Was decedent pregnant	Ectopic pregnancy			
1 Yes 2 No 3 Probably 4 Unknown 24a. Whis an appropriate completion of cause of death 1 Yes 2 No Name and address of person who completed cause of death (Item 23a) (Type, Print) 29a. Date filed (Month, Day, Year) 29b. Signal fee 3 ind file of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month,	B	e deal	sici	in the past 12 morms? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐	Other (specify)		Month Day Four	
1 Yes 2 No 3 Probably 4 Unknown 24a. Whis an appropriate completion of cause of death 1 Yes 2 No Name and address of person who completed cause of death (Item 23a) (Type, Print) 29a. Date filed (Month, Day, Year) 29b. Signal fee 3 ind file of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month,	<u>Ч</u>	d by t	Phy		nderlying cause given in Part I.	23e. Did tobar	cco use contribute to the cause of death?	
25. Was case referred to medical examiner? 26. Place of Death (Check only one)	ŝ	ires the signer		Fait II. Other signmount contained to contributing to could be the containing in the	, and a second s			m
25. Was case referred to medical examiner? 26. Place of Death (Check only one)	Ö	requ	etec			24a Wasan	24h Were autopsy findings availab	le
25. Was case referred to medical examiner? 26. Place of Death (Check only one)	Sec	has l	d m			autopsy performe	prior to completion of cause of death?	į –
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, 111 W. High St., Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Pregistrar's Signature	a	The The ficate		OS W	OC Pleas of Da			
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, 111 W. High St., Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Pregistrar's Signature	₹	sicial certi		examiner?				
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, 111 W. High St., Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Pregistrar's Signature	ō	Phy er this		27. Manner of Death 28a. Date of Injury 28b. Time of				_
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, 111 W. High St., Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Pregistrar's Signature	o	nding th. :: Afte	atio	Tending				
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, 111 W. High St., Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Pregistrar's Signature	Vis	Atter ector by th	tifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st huilding, etc. (Specify)	reet, factory, office			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, 111 W. High St., Elkton, MD 21921 State 31. Date filed (Month, Day, Year) 32. Pregistrar's Signature	ō	ital or irs after ral Dir						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, 111 W. High St., Elkton, MD 21921 State 31. Date filed (Month, Day, Year) 32. Pregistrar's Signature		Hosp 24 hou Fune stely fil	dical	(Check only 2 Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place exestigation, in my opinion, death occurred.	e, and due to the cau arred at the time, date	e and place, and due to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, 111 W. High St., Elkton, MD 21921 State 31. Date filed (Month, Day, Year) 32. Pregistrar's Signature		o the			29c. License number	290	d. Dale signed (Mdnth, Day, Year)	
Gloria Simonson, M111 W. High St., Elkton, MD 21921 State 31. Date filed (Month, Day, Year) 32. Pregistrar's Signature		->-0		DO NO MI	D005644	9	1128/04	
Gloria Simonson, W111 W. High St., Elkton, MD 21921 State 31. Date filed (Month, Day, Year) 32. Prégistrar's Signature		. /		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			
State		15						
Senistrar FER D. A. Mille Co. Co. Co. Co. Co. Co. Co. Co. Co. Co.		St. Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	9			

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artmen rtificat					giene Nog. No. 2	004	02	635
			Decedent's Name (First, Middle, Last	1)						2. Date of Dea		Vane	3. Time o	of Death
	Physicia		MARVIN EDWAR	D ROBERT	S					Month	Day 20	Year	182	J FM
Y	√Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death			nty of Deat		
			Sacred He	art Hos	spital	CI	imi	perl	and		F	fileo	jany	
	Funeral		5. Social Security Number 6. Se	7. Age	e (In yrs. last birthday	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h	9. Birt	thplace (State ountry)	or Foreign
ъ.	Director	ļ	232-48-1801	AJM ZUF	73 Yrs.					Nov. 2		Wes	st Virg	<u>inia</u>
	pu 🖈	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					-		10d. Inside (City Limits
	sho	2		_	,									s 2X No
	death with the Maryland ms 23a or 28a-f show	Director	WV Minera	11	Keyse	10f. Zip	Codo				10g. Citizen o	of What Co	huntar?	
	23a or 2		10e. Street and Number			101. 21							, or id y i	
	s 23a	Funeral	Rt. 4, Box 158	12. Was Decedent B	Ever in II S 13	Was Dece	267		igin? (Sner	cify Yes or No-		USA lace - Ame	erican Indian,	·
		'n	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?		If Yes, spe	cify Cuba	n, Mexicar	n, Puerto F	cify Yes or No- Rican, etc.)	В	lack, White		
36	hours after turel', or its	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2[X No	Specify:			Spec		White	
21215-0036	72 hours "natural"	ed	15. Decedent's Ed	ucation	16a. Dec	edent's Usu	al Occupa	ation			16b. Kind of			
5	S	Completed	(Specify only highest grad	de completed)	(Giv	DO NOT u	rk done d se retired	during mos ()	t of workin	rg				
12	I within liene.	EO	Elementary/Secondary (0-12)	College (1-4or 5	1+)	C1e	rk				Rai	llroad	d	
	be filed within that Hygiene. Ind other than event, the M	0	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,				
al	2 2 2 5	To B	Edward Earl Ro	berts, Sr	•			Lo	ola V	iolet E	verett	:		
Maryland	s 1 and 2 should be I Health and Mental Item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (7			ing Address	(Street a	and Numbe	er or Rural	Route Numbe	r, City or Tow	m, State, 2	Zip Code)	
Š	D = 1 = 0		Eileen F. Roberts	s/ Wife	Rt.	4, B	ox 1	58 K	Cevse:	r, WV	26726			
Baltimore,	of Heal		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Na)	ne of			ate	20c. Location	n - City or	Town, State	
9	permit. Peges Depertment of t Important: If its any injury or o'		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Potomac 1				J	an. 24 2004	Vouc	er, I	6277	
量	ortan		21. Signature of Funeral Service Licep		The state of the s	2. Name ar			h.				O.Y.	
B	Depermination of the police once		1 Brand	Asith		85 S.	Mai	n Str		ith Fur Keyser		26720	6	
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do not en							2012	Approxima	ate
		g 1/	shock, or heart failure. List only of Immediate Cause (Final	one cause of each lin	Lto Cl	I for I							Interval Be	Death
	Physician /Medical		disease or condition resulting in death)	a. Oun to for a	consequence of):	uc.							1041	4
	Examiner			T)	npenuean	111)						12/1/2	28
U.		e e	Sequentially list conditions, if any, leading to immediate	b. Due to or as	a consequence of):	200							0 (7	9
	uted Insit	Examiner	Cause (Disease or injury	1										
	be executed ician and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consequence of):									
760,	sicial buri	cail		đ										
89	tificate og phys as the	ed		. u.										
Вох	eath certifi attending for use as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. [Date of del	livery	
B	atter	Physiclan/M	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at		□Ectopic p □ Othe <i>r (sp</i>					٨	Month	Day	Year
O.	t the de by the tached	ysi	9 Unknown	9□ Unknown								=======================================		
Q	g 8 8		Part II. Other significent conditions co	ontributing to death b	ut not resulting in the	underlying o	ause give	en in Part I		23e. Did to	bacco use co	ontribute to	o the cause of	f death?
g	uires sign td be	d by	aprilistre	anema	2					1 🗆 Y	′es 2 □ No	3 □ Pr	robably 4	Unknown
Vital Records,	w requ	Completed	O A Mue A	8 House	. 0					24a. Was	an 24t	b. Were au	utopsv finding	is available
Be .	The lay	d L	Collins h	1 Chilly	Lalen	/				autop perfo	sy mgd?	prior to death?	utopsy finding completion of	cause of
a			25. Was case referred to medical	Ap mars	y ruseu	1			(5.0)	1 Yes	3(7No	1 🗆 Yes	2 □ No	
₹	Attending Physician: r death. sctor: After this certifics by the funeral director, i	o Be	examiner?	Hospital:	ΔΠ FD/O	00 00	Othe			(Check only			- i6 d	
ot	Phys rathis	 	1 Yes 2 No	28a. Date Inju	ry 28b. Time		JA	4 🗆 NU		ne 5 🗌 Resid 8d. Describe h			ciry)	
n	ding l	Ę l	1 Natural 5 ☐ Pending	(Month, Da	y Year) Injury	М	28c. Injun Wori 1 □ 1	k? Yes 2□						
Division of	death ctor: / the f	Certification;	3 ☐ Suicide 6 ☐ Could not be		ury - At home, farm, s			- 55		8f. Location (5	Street and Nur	mber or Ri	ural Route Nu	ımber,
i≥	or after Dire	erti	4 ☐ Homicide determined	building, et	c. (Specify)		,,			City or Tou	m. State)			
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledge, dea	ith occurred	at the tim	ne, date an	nd place, a	nd due to the	cause(s) and	manner as	s stated.	
	24 h 24 h 3 Fur etely	Medical			examination and/or									e(s)
	To the within 2 To the comple	₩	29b. Signature and title of certifier	200	11 -11	29	c. Licens	e number			29d. Date sign	ned (Mont	th, Day, Year)	
	⊢ \$ ⊢ ō		> Kich and	1 (c) A1	+118The		()	21	33	3	1/7	3/1	301	
	C.		30. Name and address of person who	completed cause of	math (Item 2100 aTuni	PrintV	<u>.</u>	00	7)	4	1	4	•
	X		O. Hame and address of person will be	O TAN	10 - (11	Mala	. 1	Well	2	1079	lι R	Richa	rd Schi	mitt,M
J. R.	Sta	ate.	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	VVVJ	, ,	4	W/	500	4			
	Regist	-	FFR 0 2 2004	France .	11 Anna	R A								

					partment of Health and N		
			1 - For State Registrar		ertificate of Death		g. No. 2004 02636
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici		ARSELL THEODORI	E ROBINSON		Month January	Day Yeer 27 2004 12:00 p M
	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)	4b. City, Town, or Location of Death		4c. County of Deeth
			IVY HALL ELDER CAR		BALTIMORE		BALTIMORE CO
	Funeral		5. Social Security Number 6. Sex	M OFF	Months Davs Hours Min.	8. Date of Birth (Month, Day, March 5,	9. Birthplace (State or Foreign Country)
24.5	Director		216-34-2135 Usual Residence of Decedent	65 Yrs.		March 5	, 1938 MARYLAND
	yland now		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	B-f st	cto	MARYLAND BALTIN	MORE CO BA	LTIMORE		1 ☐ Yes 2 ☒ No
	or 28	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
	ath w	a	606 DELAWARE AVE		21221		U.S.A.
	er de Items	Funeral	The state of the s	Was Decedent Ever in U.S. Armed Forces? The Armed Forces?	 Was Decedent of Hispanic Origin? (Sport of Yes, specify Cuban, Mexican, Puerto 	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Oivorced	1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: BLACK
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, I'm Medical Exactiver must be rotified at	ted	15. Decedent's Educ	ation 16a. De	cedent's Usual Occupation	10	6b. Kind of Business/Industry
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	ve kind of work done during most of won DO NOT use retired)	King	
2	filed withi Hygiene. other than	ပ္ပ	12th grade	ADM	I PUBLICATION		FEDERAL GOVERNMENT
and m	be fill stal H od otf	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Mi	
Maryland	should be filed within and Mental Hygiene. s marked other than umatic event, ILA M	2	EUGENE ROBINSON 19a. Informant's Name/Relationship (Type	on Print) 10h Ma	MLLDR uiling Address (Street and Number or Ru	ED ROBINS	
Ma	2 2 2 2		ANTOINE ROBERTSON		-		
ē,	es 1 and 2 should of Health and Men f item 27 is marke r other treumatic		20a. Method of Disposition	20b. Place of Dis	7 N BENTALOU ST., sposition (Name of rematory or other place)		Dc. Location - City or Town, State
Baltimore,	0 0		XXBurial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State		0-04 E	BALTIMORE, MARYLAND
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		22. Name and Address of Facility	3 8 -	
B	Depa Impo any ir		Marles H	Cowell	1206 W NORTH AVENU	E WWONITY E	FUNERAL HOME P.A.
	Physician /Medical Examiner	Iner	shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	oma Lungs with	Brain	Mekashy un Kuan
,092	le be executed ysician and e burial-transit	i Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):		-	
6876	cate b	dicai	d				Danity (2004) 2002
P.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
of Vital Records, P	luires that n signed b	Completed by Pi	Part II. Other significant conditions conf	tributing to death but not resulting in the \mathcal{DPD} , \mathcal{C}			acco use contribute to the cause of death?
000	aw requir s been si s should	olete	CVA.			24a. Was an	24b. Were autopsy findings available
R	The law	E O				autopsy performe	
ital	ysician: The l is certificate ha director, page	Bec	25. Was case referred to medical examiner?		26. Place of Dea	th Check only one	
>	Physic this ce al dire	2	1 □ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpat			ce 6 □Other (Specify)
no	After 1	iuo!	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) 1njur	y Work?	28d. Describe how	injury occurred
Division	ttend death stor: ,	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f Location (Stre	et and Number or Rural Route Number,
Οİ	after Direction by	ertif	4 ☐ Homicide determined	building, etc. (Specify)	street, ractory, office	City or Town,	State)
	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifier (Check only one)	leian. To the best of my knowledge, do er: On the basis of examination and/or and manner stated.	ath occursd at the time, date and place investigation, in my opinion, death occur	, and due to the cau rred at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)
_	Fo the within Fo the comple	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month, Day, Year)
	- >- 0		Morac M.		D-3875	+ (01-27-2004.
	3		30. Name and address of person who cor	npleted cause of death (Item 23a) (Typ BAM . 709.		ID. 1	MD-21221
2	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	Cart 1		
	Regist	rar	FFB 0 2 2004	10 1912 AS AS	and the state of t		

		•	For State Registrar	State of Maryland / [Department of Health and Certificate of Death	Mental Hygier	- 2001 - 00com
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) FRANCIS 2112 4a. Facility Name (If not institution, give s	aboth Reidy	4b. City, Town, or Location of Dea	2. Date of Death Month D	Day Yeer 3. Time of Death Ac. County of Death
	Examin Funeral Director	er	FRANKLIN SQUAR 5. Social Security Number 6. Sex 213-26-3984	Absoital	Rosedale	s. 8. Date of Birth	Baltimore
	ith the Maryland or 28e-f show	tor	Usual Residence of Decedent 10a. State 10b. County Baltimor	e Parky	n or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the s 23a or 286	Funeral Director	10e. Street and Number 32110 Spell Ct.		10f. Zip Code 2/234		Citizen of What Country?
920	urs after de al', or Items Examiner n	by	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. sther than *natural; or Items 23s or 28e-f show ant. Ite Medical Examinat mital be institled at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) 16a College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16b.	Kind of Business/Industry
Maryland 2	2 should be filed and Mental Hyg Is marked other aumatic event.	To Be C	17. Father's Name (First, Middle, Last) MICHAEL A. E	Ruder	18. Mother's N	ame (First, Middle, Maide Leth R. 1	Maetin
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other traumatic event. I'm Nedical Examinating Indianal Medical Examinating Indianal Medical Examinations on the restriction of the second of the sec		19a. Informant's Name/Relationship (Typ. 20a. Method of Disposition	1. SR - Mus. 3 20b. Place o	Mailing Address (Street and Number or I	altimore	y or Town, State, Zip Code) 2134 Location - City or Town, State
Baltimore,	permit. Page Department of Important: If any injury or ance.		1 Disurial 2 Cremation 3 Ri 4 Donation 5 Other (Specify) 21 Signature of Funeral Service License	Most Ho	22. Name and Address of Facility	004 Ba Vans Funer	Chaple Maryland
	Physician /Medical		23. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ac or respiratory arrest,	Approximate Interval Between Onset and Death
,eo,	be executed icien and purial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence) Due to (or as a consequence)	of):		
P.O. Box 68760	certifica ding pt se as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	tc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	The law requires that the death tie has been signed by the atter bage 2 should be detached for L	by	Part II. Other significant conditions con		n the underlying cause given in Part I.		o use contribute to the cause of death?
al Reco	The lav	Completed				24a. Was an autopsy performed?	
Division of Vital Records,	To the Hospital or Attending Physician: The lawinin 24 hours after death, To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To Be	25. Was case referred to medical examiner? 1 Yes 25 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b.	0.1	eath (Check only one) Home 5 Residence 28d. Describe how in	
Divisi	tal or Attents after deal	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	the Hospi hin 24 hour the Funer mpletely fill	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	icien: To the best of my knowledge er: On the basis of examination ar and manner stated.	e, death occurred at the time, date and pland/or investigation, in my opinion, death occurred 29c. License number		(s) and manner as stated. Indicate, and due to the cause(s) Date signed (Month, Day, Year)
	2 3 2 3	1	1	moleted cause of death (In- CC)	0-348	3 (1 25 04
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 2	Efill 4136 B	b. Soppard. B.	altemore, 1	4D 212360

			riease i			delible ink. Ensure A			
			1 _ For	State of Mary	•	artment of Health and M	ventai Hygie	0001	00000
			Registrar		Cer	tificate of Death		No. 4	
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2000		2. Date of Death Month	Day Yeer	3. Time of Death
	/Medic		FRED HU	STIN	KOSS.		JANUARY	24, 2004	12:01 KM
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)	1	4b. City, Town, or Location of Death		4c. County of Deet	h
н			GOOD SAMA	RITAN H	OSPITAL	BALTIMORE		W/x	7
5	Funeral		5. Social Security Number 6. Sec	M 2□F	yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	hplece (State or Foreign untry)
	Director		216-30-2260	M 2UF	69 Yrs.		4-21-8	34 VIA	ajnia.
	p ,		Usual Residence of Decedent	100	c. City, Town or Loc				10d Janida Cia Libria
	anyla mhov	<u>_</u>	10a. State 10b. County	100	_				10d. Inside City Limits 1 Yes 2 No
	Ba-f	cto	MD		BAL	TIMORE			1 A 162 2 140
	or 2	by Funeral Director	10e. Street and Number		1	10f. Zip Code	10g.	Citizen of Whet Co	untry?
	23a	- E	1101 DUNRO	ming B	d.	21239		USA	
	ame arme	ne	11. Marital Status	12. Was Decedent Ever Anned Forces?	in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
9	afte or It	Ŧ	1 Never Married 2 Married	1 DYes 2 □ No If Yes, Give		☐ Yes 2 No Specify:		Specify: /. 1	1 . 1 .
8	ours aral',	d b	3 Widowed 4 Divorced	Year or Dates:				Specify W	nite.
Š	72 h netu	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	lent's Usual Occupation kind of work done during most of work	king 168	o, Kind of Business/	Industry
7	within lene. than	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT use retired)		Ch. 11	n + 1
2	Hygier Hygier Ither th	ပ္ပ	12		1/00	manic		STUEF 1	neral.
р	d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Mai	den Sumame)	
<u>a</u>	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I markad othar than *natural', or Itame 23a or 28a-f ahow umatic avant, Ita Medical Etairinal russi be notified at	2	nou Koss			Stell	a Lan	Rum.	
an	2 sho and is my		19a. Informan Name/Relationship (Ty	oe, Print)	19b. Mailin	g Address (Street and Number or Rui	ral Route Number, C	ity or Town, State, Z	ip Code)
Σ	1 and 2 Health em 27		Robin Manle	1	411	Summit-DR. E	allston.	mD 21	1047
ore	of He of He fiten		20a. Method of Disposition 1 □ Buriai 2 1 □ Figure 1 □ Figure 2 □ Figure 2 □ Figure 2 □ Figure 3 □ Figure		Ob. Place of Dispos cemetery, crem	natory or other place)		. Location - City or	
Ĕ	Pages nent of int: If it		`4 □ Donation 5 □ Other (Specify)		JANS FUL	1510 M CHAPEI - 1" 3	1-04 F	rost Hi	11 mD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itame 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examinat must be notified at once.		21. Signature of Funeral Service License		22.	SERAL CHAPEL 1" 3 Name and Address of Facility 232	25 YORK R	D. Timonic	mm
m	Departiment of the particular		*Kimberly 1. 1	MUNITARY	TE	ACFFIL ALTERNATI	VES FUNER	PALOCRE	MATION CTA
	- 4		23a. Part1. Enter the disease, or compli- shock, or heart failuge. List only/or	ations that caused the	death. Do not ente	or the mode of dying, such as cardiac			Approximate Interval Between
	Physician		Immediate Cause (Final)	O Cause of each line.	1:1	Tutostan			Onset and Death
	/Medical		disease or condition resulting in death)	Due to lor as a cor	rsequence of):	_ LIKE C/OIC	-		
П	Examiner			/	, , , , , , , , , , , , , , , , , , , ,				
	100	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	isequence of):				
	uted ansit	듣	Cause (Disease or injury that initiated events						
<u> </u>	exec in an ial-tr	Examiner	resulting in death) Last	Due to (or as a cor	nsequence of):				
760,	ite be executed ysician and he burial-transit	cal							
68	ificat g phy as th								
Вох	ndin use	Z.	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr		_		23d. Date of deli	very
Ď	death certifica e attending ph ed for use as th	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐ 4☐Pregnant at time		Ectopic pregnancy Other (specify)		Month	Day Year
9. O.	that the death certifical ed by the attending phy detached for use as th	hys	9 Unknown	9□ Unknown					
<u></u>	The law requires that the ate has been signed by the page 2 should be detache	by Physician/Medi	Part II. Other significant conditions con	tributing to death but no	t resulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ğ	aure n sig						1 🗆 Yes	2 No 3 Pro	obably 4 Unknown
00	w red	Completed					24a. Was an	24b. Were au	topsy findings available
Re	he lav e has ige 2	E					autopsy performed	l? death?	ompletion of cause of
a	ificati or. pa		25. Was case referred to medical			00 Pi 4 P	1 Yes 2	No 1 ☐ Yes	2 No
₹	Physician: r this certifica ral director, p	o Be	examiner?	ospital:	2 ER/Outpatient	Other	h (Check only one)		~ .
of	Phy rald	1: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	ome 5 Residence 28d. Describe how i		ary)
on	ding th. Afte	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At home, farm, stre	eet, factory, office	28f. Location (Stree	t and Number or Ru	ral Route Number,
ă	after Direct	Certification;	4 Homicide	building, etc. (Sp	oecify)		City or Town, S	tate)	
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Phys	Ician: To the best of my	knowledge, death	occurred at the time, date and place,	and due to the cause	e(s) and manner as	stated.
	e Ho 1 24 h	edical	(Check only 2 Medical Examination)	ner: On the basis of examend manner stated.	mination and/or inv	estigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	. 0		29c. License number	29d.	Date signed (Month	, Day, Year)
	7		12 dinno	Alin	\mathcal{N}	D38956	JA	NUARY 20	a annu
	2/1		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, F	Print) 5601 LOCH R	AVEN BO	ILEVARI)	1-007
	UNI			EIDEL, N	20	29c. License number D38956 Print) 5601 LOCH R B.ALTIMORG	MARYKAK	0 71.7	19
É	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's S	inature	H. Angelle)		- CV/3V3	
	Registr	ar	FEB	U K C 1 1	Salded 1				

			1 - For State Registrar	State of	Marylaı	nd / Depa <i>Cei</i>	artment rtificate					giene Reg. No. 2	2004	0.2	639
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Month							
7.11	/Medic	cal	Dora Bell 4a. Fecility Name (If not institution, give street and number)				Sellars Janua 4b. City, Town, or Location of Death					ry 25 2004 05:47 M			
	Examir	ner	Sinai Hospital		J 0 1)		Balt			n Dealin		40.00	unty or Deatt		
**	Funeral		Social Security Number 6. Se	x 7	-	. last birthday)	If Under 1			24 Hrs. Min.	8. Date of Birtl (Month, Day	h v. Year)	9. Birth	place (State	or Foreign
	Director		213-28-6826 Usual Residence of Decedent	м 200€	80	Yrs.	, violinio				07 2		3 1	ĬĆ	
7	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside	City Limits
,	a-f eh	ctor	MD NA		Ba.	ltimor	·e							XXYe	s 2 No
	or 28	Dire	10e. Street and Number		-		10f. Zip (Code		·		10g. Citizen	of What Cou	intry?	
	s 23e	eral	2109 Poplar Gro	ve Str		16 122	Man Danada		216	-:-2 /0			J.S.A.		
(0	riter d	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Ford	es?					n, Puerto R	ofy Yes or No- lican, etc.)		Black, White		
8	ours a		3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dai			1 □ Yes 2	No No	Specify:		_	Sp	ecity:	3lack	
5	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f ehow the Modical Exemples must be confiled at	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>		(Give	dent's Usual kind of work DO NOT use	done di	urina most	t of workin	g	16b. Kind o	of Business/Ir	ndustry	
7	withir iene. r than	dmo	Elementary/Secondary (0-12)	College (1-	4or 5+)	-	embl	,				Roper	East	ern	Corp.
פ	al Hygid other vent,	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Sur	mame)		
ylaı	should be ind Mental s marked o umatic eve	2	Ed Brown								nton				
Mar	d tra		19a. Informant's Name/Relationship (T)							_	Route Numbe				
<u>6</u>	permit. Pages 1 and Department of Heatth Important: If Item 27 eny injury or other tr		Hope Oliver-Day 20a. Method of Disposition	gnter	20b.	Place of Dispo cemetery, cren				ad, Da	Hanov		ion - City or T		
Ë	Pages nent of int: If it iny or o		1 🔀 Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		ate	Meado				1/21	/04	Flbri	.dge,	MA	
Baltimore, Maryland 21215-0036	permit. Departmitmoporta		21. Si thature of Funeral Service Licens	88	1	22	Name and	Address	of Facility	v	704 1	DIALI	uger	nu	
Ш	80 F 9 9		Flynes D	Re	te	43	00 W	abas	sh A	ve,	Balti		Md 2	21215	
	Physician /Medical Examiner		23a. Pant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearhaulture. List only one cause on each line. Immediate Cause (Final disease or condition Athles Scletchic Caedovascular Di Scasp Geal or										etween		
			disease or condition resulting in death)		heed rasaconse		onc	a	edit	vasi	erkar	Dis	case	Jea	28
		Iner													
	p #s		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
•	xecute and	Examiner	that initiated events resulting in death) Last	Due to (o	r as a conse	quence of):									
8760,	cate be executed physician and the burial-transit	dical		i											
9	rtificat ng ph) as th	Medi	IF FEMALE:												
Вох	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		h 2 Fet	aldeath 3□	Ectopic pre					23d.	Date of deliving Month	ery Day	Year
0	0 0	yslc	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregna 9□ Unknov	nt at time of o	death 5□	Other (spe	cify)					.v.or.ur	July	7 041
S, D	The law requires that the tee has been signed by the page 2 should be detached.	by Ph	Part II. Other significant conditions con	ntributing to dea	th but not re	sulting in the ur	nderlying cau	ıse giver	n in Part I.		23e. Did to	bacco use o	contribute to t	he cause of	death?
rds	w requires been sign should be	ed b	Hypertens	un							1 🗆 Y	es 2 N	o 3∏Prol	ably 4]Unknown
Vital Record	has be	Completed	tigpee libid	lemia							24a. Was a		4b. Were auto	ppsy findings impletion of	s available cause of
<u> </u>			UV 1								perfor 1 ☐ Yes	med? 2 No	death?	210 No	
<u> </u>	Attending Physician: Thir death. ector: Atter this certificate by the funeral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	estiont 2] ER/Outpatien	• • • • • • • • • • • • • • • • • • •	Other			Check only or				
o c	g Phys ler this neral di	n; To	27. Manner of Death	28a. Date of		28b. Time of	1 3 DOA 4 Nursing Home 5 N Res.					how injury occurred			
Sior	uttendin death. ctor: Af y the fur	catlo	1 Avatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(inchia)		injuny	М		es 2 🗆 N	No					
Division of	i Site	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	f Injury - At h g, etc. <i>(Speci</i>	nome, farm, str ify)	eet, factory,	office		28	If. Location (Si City or Town		umber or Rura	al Route Nur	mber,
_	pite ours ille		29a. Certifier Certifying Phy	sician: To the b	est of my kn	owledge, death	occurred at	the time	a. date and	d place, an	nd due to the c	ause(s) and	I manner as s	tated	
	To the Hos within 24 h To the Fun completely	Medical	(Check only 2 Medical Exami	ner: On the bas and manne	is of examina	ation and/or inv	restigation, i	n my opi	nion, deat	h occurred	d at the time, d	late and place	ce, and due t	the cause	(s)
	To t To t	Σ	29b. Signature and title of certifier	0. 40	11.10			License		,	2	1.	gned (Month,	Day, Year)	
		3	20 Name and addition	vuvu.		- 00.1 -		52	-158)			30/04		
			30. Name and address of person who co	nipieted cause	57 G	m 23a) (Type, 1	Uho	Pea	2 2	wite.	108 C	echon ?	willo	MA	2/228
	Sta		31. Date liled (Month, Day, Year)		gistrar's Sign	ature	J		2,0		. 0,	-1	-		1-00
	Registr	ar	EED U	2 2004	13	Let.	1	no 2							

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar AMEND TITEM #2	State of Maryland / De PER PHY G828 2/02/04/	partment of Health and M H Prtificate of Death	ental Hygier	2004 112641		
			Decedent's Name (First, Middle, Last			2. Date of Death	3. Time of Death		
	Physici		Rohoot	+ SWINTON		Month E	8 2004 12:30 PM		
	/Medio Examin		4a. Fecility Name (If not institution, give	street and number)	4b, City, Town, or Location of Death		4c. County of Death		
	LXdiiiii		Fiture Care	ald Count	Kandallstown		Baldo.		
	Funeral		5. Social Security Number 6. S			8. Date of Birth (Month, Day, Yee	9. Birthplace (State or Foreign		
	Director		214-22-0907	□M 21/4F 90 Yrs	S. Working Days 110015 Will.	Sept 17, 19	13 South Carolina		
	D >		Usual Residence of Decedent 10a. State 10b. County	10c. City. Town o	r Location	/ /	10d. Inside City Limits		
	shor	Director	la 1	+ Baldir			1 XYes 2 No		
	28a-f		10e. Street and Number	Dalov	10f. Zip Code	100 (Citizen of What Country?		
	with		Toe. Street and Number	DI	2 1133	109. ((1 C)		
	death with the Maryland ms 23a or 28a-f show findal be fieldfad at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.		cify Yes or No-	14. Race - American Indian.		
	fier d	듄	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 M2No	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto) 	Rican, etc.)	Black, White, etc.		
036	urs a	ğ	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black		
21215-0036	within 72 hours after ene. then "natural", or Ite	Completed	15. Decedent's Ed	fucation 16a. De	ecedent's Usual Occupation live kind of work done during most of working	16b.	Kind of Business/Industry		
21	thin 7	Pie.	(Specify only highest gra	College (1-4or 5+)	fe. DO NOT use retired)	<i>'</i> 9	7 /		
21	ed wi	ဉ် ပ	9		ousikeeper		Domestic		
pu	tal H d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maide	an Sumame)		
<u>×</u>	ould Men Marke	ို	1-0/2-1	Jamih	Enma	Hudson			
Maryland	l 2 sh		19a. Informant's *ame/Relationship	S 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lailing Address (Street and Number of Rura	DI	11 0 0 - 12 - 1		
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Exam.		20a. Method of Disposition	lage Nieee	isposition (Name of D	1 Ce JV.	Location - City or Town, State		
وّ	permit. Pages 1 Department of H Importent: If itel any injury or ott		1 ⊈Burial 2 ☐ Cremation 3 ☐	Removal from State	crematory or other place)	200.	A. A. A. A. A.		
altimore,	it. Pi		 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer 		22. Name an Address & Facility	2004/4	ne Mindel, Ud.		
Ba	Depariment of the population o		21. Signature of Fulleral Service Licer		Carlos C. Donglass	tuneral	to . Wd . 21217		
	1.000		23a, Part1, Enter the disease, or com	dicetions that caused the death. Do not	enter the mode of dying, such as cardiac o	24.	Approximate		
	White 12 4 Co.		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			Interval Between Onset and Death		
7	Physician /Medical		disease or condition resulting in death)	a. ALCOHOLIC L Due to (or as a consequence of):	- IVER CIRMOSS	15			
	Examiner			b					
	be executed sician and burial-transit	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
		Examiner	that initiated events	c					
oʻ		EX	resulting in death) Last	Due to (or as a consequence of):					
8760,	cate be ex physician the buria	dicai		d					
9		Mec	IF FEMALE:						
B0)	Attending Physicien: The law requires that the death certific refath. rdeath. sctor: After this certificate has been signed by the attending p the funeral director, page 2 should be detached for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year		
0	the a	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		-,		
σ.	that the	P.	Part II. Other significant conditions of	ontributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?		
ds,	uires tha signed d be de	d b		ENAL FAILUR		1 ☐ Yes	2 □ No 3 □ Probably 4 ☑ Unknown		
Ö	v requ been shoul	ete	ANEMIA			24a. Was an	24h Were autoney findings available		
Re	he lar s has ge 2	Completed	THIV CIVITY			autopsy performed?			
a	sician: The lav certificate has rector, page 2	ပ္	25. Was case referred to medical		26. Place of Death	1 Yes 2XN	lo 1 Yes 2 No		
>	ysicia s cert direct	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			6 □Other (Specify)		
0	g Phys erthis eraldi	i i	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at 2	8d. Describe how in			
jo	ath. rr: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation						
Division of Vital Records, P.O. Box	r Atte	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	8f. Location (Street a	and Number or Rural Route Number,		
	Itato Irsaft ral Di Iedin								
	Hosp 24 hou Fune Fune tely fi	Medical	(Check only 2 Medicel Exen	niner: On the basis of examination and/o	eath occurred at the time, date and place, a r investigation, in my opinion, death occurre	and due to the cause and at the time, date a	s) and manner as stated. nd place, and due to the cause(s)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Mec	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29d. D	Pate signed (Month, Day, Year)		
	F ¥ F 8			· D	D0059107		-30-2004		
	3		V ~ 3	completed cause of death (Item 23a) (Ty			- 30- 2007		
			KALU UMA			BALTIMORS	M.D. 21215		
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signature	MEICHTS AVENUE	2101111111			
	Registr	ar	EER 0 2 200	4 Flancis So All					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth _ Month **Physician** 9:03Am January 26 2004 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Rosedale ranklin square HOSP 1+0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F 213 - 42 - 4856 Usuel Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner mast be notified as 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11, Maritel Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Steen, Richard 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify. Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Jan 28 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Salvice Lioshsee 22. Name and Address of Facility (Majori 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of rlying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ·lolyngeo Examiner Physician/Medical Examiner Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Box 68760 Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? this certificate 1 Tas 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2□ ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☑ No edicai Certification: To 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours after death.

To the Funeral Director: A completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in by the formal completely filled in the formal completely

State Registrar

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

Shinners 9000 Franklin square Drive Baltimore MD.

mumes!

32. Registrar's Signature

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

FEB 0 2 2004 >

29c. License number

29d. Date signed (Month, Day, Yeer)

		For State Registrar	State of Maryland / Dep	partment of Health and I ertificate of Death	Mental Hygie	grow and ditt	02612			
y'		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death			
Phys	ician dical		5 PENCER	ζ.	JAN 27	Day Year	4:45PM			
Exan				4b. City, Town, or Location of Death	1	4c. County of Death				
		2916 OAK	crest Ave	BALTIMOR	e ,	NIB				
Funer Directo		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthplac Country,	(State or Foreign			
Annual Control	, ,	Usual Residence of Decedent	7 10		June 2, 19	707	1410)			
ryland		10a. State 10b. County	10c. City, Town or	<u> </u>		10d.	Inside City Limits			
e Ma	Director	MD NI	3	BALTIMORE			YOS 2□No			
Aith th	Dire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country	?			
s 23s	8	2916 OAKCTES		21734		U.S.A.				
Iltimore, Maryland 21215-0036 iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other treumatic event, it a Medical Exercises must be notified at	v Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	 Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☐ No Specify: 	pecify Yes or No- o Rican, etc.)	14. Race - American Black, White, etc				
DOC hours	od by	3 Widowed 4 Divorced	Year or Dates:		1.00	whil	10			
157 in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Giv	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired)	king	. Kind of Business/Indus	stry			
2121 J within piene. r than		Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMAKER		Home.				
be filed tal Hyging of other	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	den Sumame)				
Vlar	P			ANNA	HildeBRI	4UN				
Maryland 21215-0036 at 2 should be filed within 72 hours at the and Mental Hygiene. To is marked other than "natural", or treumetic event, the Medical Exercitive Comments.		19a. Informant's Name/Relationship (Typ		ling Address (Street and Number or Ru	—		ode)			
D, N l and lealth im 27 her ti		JUSEPH SPENCE	20b. Place of Disp	6 BAGIEY AVE	Balto Nu					
Pages 1 nent of H int: If ite		20a. Method of Disposition → Burial 2 Cremation 3 □ Re	moval from State cemetery, cri	ematory or other place)		Location - City or Town,	, State			
Baltimore, permit. Pages 1 a Department of Hez Important: If item any injury or othe		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses		D Cemetery 1 31		ite i My	· · · · · · ·			
Depart Fundament	Suc	Jaul M.	Stills	22. Name and Address of Facility (+ ARTICY MillER - 5 537 harford RD	Balto-M	ACRAL HOME	CHID			
		23a. Parti. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not electure on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Ap	proximate terval Between			
Physicia	_	Immediate Cause (Final disease or condition	CongestiVE He	ann Frience		Z	pset and Death Oughts			
/Medica Examine		resulting in death)	Due to (or as a consequence of):				7			
	e e	Sequentially list conditions, b. The any, leaging to immediate to consequence of the con								
uted										
18760, cate be executed physician and the burial-transit	Examin									
8760, cate be ex physician the buria	dlcal	d.								
rtiffica ng ph	Med	IF FEMALE:								
death certific death certific e attending p	any	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of delivery Month Da	v Year			
• D 0 D	Physician/Me	1 □ Yes 2 ☑ No 9 □ Unknown	4□ Pregnant at time of death 5 9□ Unknown	Other (specify)		Month Day	у төаг			
det the			ributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	Did tobacco use contribute to the cause of death?				
VItal HECORDS, P.O sicien: The law requires that the certificate has been signed by th rector, page 2 should be detache.	yd by	î			1 🗆 Yes	2 No 3 Probably	y 4 🗆 Unknown			
COrd w requir	Completed				24a. Was an	24b. Were autopsy	findings available			
The law The has b	Ë				autopsy performed 1 ☐ Yes 2 ☐	prior to comple death?	etion of cause of			
VITAL P Ician: Th certificate ector, pag	BeC	25. Was case referred to medical		26. Place of Dea	th (Check only one)	10 10 20	3 140			
- × v	10 E	1 ☐ Yes 2 ☐ No Ho	spital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify)				
ng Pi										
VISION Attending r death. ector: After	cat									
DIVISION OF It or Attending Phy after death. I Director: After this din by the funeral d	Certification:	289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
DIVISION O' To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		cian: To the best of my knowledge, dea er: On the basis of examination and/or i and manner stated.	ith occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated and place, and due to the	d. o cause(s)			
o the rithin o	Me	29b. Signature and title of certifier	with mariner states.	29c. License number	29d. [Date signed (Month, Day	, Year)			
⊢ s ⊢ ŏ		> When mo		D53445						
3		30. Name and a rest of person who com	upleted cause of death (Item 23a) (Type	o, Print)	0/1	7 - 7	-			
		ROBERT TUNNER,	MD 7600 056	D53445 Dr. Suife 311	Cowsen N	W 21204				
	tate	31. Date filed (Moлth, Day, Year)	32. Registrar's Signature	-						
Regi	strar	WEED 0 0 2004	Les P be de	RS 0						

ORIGINAL

		•	For State Registrar	i icasc	State	of Marylan		artmen rtificat			and M	lental Hy	giene ,	2004	02643	
ę	Physici		Decedent's Name (First, Middle, Last) 2. Date of Death Month Day								2004	3. Time of Death 10:30 P M				
H _i Sa	/Medic Examin	1	4a. Facility Name (If I			C.			4b. City, Town, or Location of Death TIMONIUM					4c. County of Death $BALTIMORE$		
100	Funeral Director		5. Social Security Nu 095-42-35	81	Sex 1 □ M 2 🔯 F				f Under 1 Year If Under 24 Hrs. 8. Date of Bi conths Days Hours Min. July 1				9. Birthplace (State or Fo			
Maryland 21215-0036	ehow ed at	٥٢	Usual Residence of D 10a. State MD	10b. County Baltimo	re	10c. City, Town or Location Timonium									10d. Inside City Limits 1 ☐ Yes 2√ No	
	with the N a or 28a-1 be notifi	Direct	10e. Street and Num 2300 Dul	ber		ey Road 21093				}		-	en of What Co	ountry?		
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural" or Itams 23a or 28a-f ehow maric event. the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☑ Never Marrie 3 □ Widowed 4	12. Was Der Armed F 1 □ Yes If Yes, G	1 □Yes 2VNo		Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No Specify:					o- 14. Race - American Indian, Black, White, etc. Specify: White				
	vithin 72 hor ne. han "natura ne wed call i	Completed	(Specification (Speci	15. Decedent's E y only highest gi dary (0-12)	ade completed	de completed) (Give life.		dent's Usual Occupation kind of work done during most of working DO NOT use retired)					16b. Kind of Business/Industry			
land 5	be filed ital Hygi d other event,	To Be Co	17. Father's Name (F	First, Middle, Las Schrami		5+			teacher 18. Mother's Name (F					umame)	10d. Inside City Limits 1 □ Yes 2√ No What Country? A De - Americen Indian, ck, White, etc. y: White usiness/Industry ucation me) State, Zip Code) 21218 - City or Town, State Approximate Interval Between Onset and Death atte of delivery onth Day Year tribute to the cause of death?	
Mary	" 2 - 2		19a. Informant's Nar Sister of			ne, Print) 19b. Mailing Address (St. 3725 Ellers										
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra <u>pnce</u> .		20a. Method of Dispo 1 ☐ Burial 2 ☐ 1 ★ Donation	Cremation 3	Place of Disposition (Name of Cametery, crematory or other place) Date						Date	20c. Location - City or Town, State				
Balti	permit. Departm Importa any inju			Ronald S. Hade, Birector State Anatomy Board 655 W Baltimore, MD 21201						Balı	Street					
	nysician	5 9	23a. Part . Enter the shock, or heard lmmediate Cause (Fidisease or constitution resulting in death)	failure. List only	plications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each life. Approximate Interval Between Onset and Death											
	/Medical Examiner		Sequentially list conditions.	b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
,092	ate be executed hysician and he burial-transit	I Examiner	Sequentially list con if any, leading to imicause. Enter Under Cause (Diseese or i that initiated events resulting in death) L	_	c	C										
89	ntificate t ng physic s as the b	Medical	IF FEMALE:	•	d								111-			
P.O. Box	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Completed by Physician/Med	23b. Was decedent in the past 12 r 1 Yes 2.2 9 Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					d tobacco use contribute to the cause of death?						
	quires that in signed by uld be deta	ed by Ph	Part II. Other again cant conditions contributing to death but not resulting in the underlying cause given in Part I.													
l Records,	The law requir ate has been si page 2 should	Complet	76	1410	V3 7 7		_L/ 25	* H_				24a. Was auto perf 1 Yes	an psy prined? 22190	24b. Were au prior to death?	utopsy findings available completion of cause of 2 No	
Vital	Physician: The la ir this certificate has aral director, page 2	Be	25. Was case referr examiner?		26. Place of Death (Check or Hospital: Other:											
-	Attending Physic death. •ctor: After this by the funeral di	ation: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investig		28a. Dat (Mo	28a. Date of Injury (Month, Day Year) 28b. Time of Injury				IT 3 DOA 4 LANUTSING HOME			d. Describe how injury occurred			
	P = E	Certification:	3 Suicide 4 Homicide								Location (Street and Number or Rural Route Number, City or Town, State)					
	Hospitel 24 hours at Funeral D letely filled i	edical (29a. Certifier (Check only one)	Certifying F	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								s stated. to the cause(s)			
)	To th within To th compl	Me	29b. Signature and title of Certifier						29c. License number				29d. Date signed (Month, Day, Year)			
			30. Name and addre	oss of person wh			m 23a) (Type		EY R	OAD	TIMC	ONIUM.	MD 21	09.3		
	St Regist	ate rar	31. Date filed (Mont	th, Day, Year) 3 0 2 200)4	Registrar's Sign	ature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #17618 per informant Co33 of Feath and Mental Hygiene
Certificate of Death
Reg. No. Reg. No. 2004 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6000 AM SPEVAK FRANK 39 2004 lanuary /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore If Under 24 Hrs. Baltimore Medical 1000 Birthplace (State or Foreign Country) 8. Date of Birth JAN. 23, 1927 7. Age (In yrs. last birthday) rear **Funeral** Days Hours 1 M 2 □ F 215-24-5191 77 Yrs. MD Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State wode 7 is marked other then "natural", or Itama 23a or 28a-f ehov traumatic event, the Medical Examinatin ust be notified at 1 Tes 2 No Director BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 U.S.A. 1 HIGHSTEPPER COURT #501 , or Itama 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** MEAT PACKING ealth and Mental Hv. 17. Father's Name (First, Middle, Last) Jacob Spevak 18. Mother's Name (First, Middle, Maiden Sumame)
Rebecca Frieman DORIS SFIRIFS. -NATHAN-SPEVAK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CYNTHIA POTLER / DAUGHTER 6810 PIMLICO DRIVE - BALTIMORE, MD 21209 permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other 1 20028. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MOSES MONTEFIORE CEM, 1/30/2004 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Onement Physician ZHYNE nervoussystem disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): physician Physician/Medical attending pt for use as ti IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ö 9□ Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, been signe should be Kenal 2 No tailure 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No npatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of D ath 1 Natural 2 Accident Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the within 24 hours after deat To tha Funaral Diractor: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ò Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier froerson, who completed cause of death (Item 23a) (Type, Print) 6569 North Charles St. evine

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Register's Signature

2004

		For State Registrar		State of	Maryla	nd / Depa	artmen rtificate				Mental Hy	/giene Reg. No	20	04	026	45
Physici /Medic		1. Decedent's Name (First, Middle Amelia Helene		aley		,					2. Date of D Month Januar	Da	3, 20	Year 004	3. Time of 0	
Examin		4a. Facility Name (If not institution 202 Maryland A			nber)		4b. City, Hanc		Location of	of Death				of Death		
Funeral Director		5. Social Security Number 132-07-5368	6. Sex 1 🗆 N	u 2 ∏ F	7. Age (In yrs	s. last birthday) 84 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D November	3,19	19	9. Birth Cou PA	place (State or ntry)	Foreign
Maryland f show	٥	Usual Residence of Decedent 10a. State 10b. County	n 0 tr 0 tr			City, Town or Lo	ocation								10d. Inside City	•
with the ? 3a or 28a- if be notif	Funerai Director	MD Washi 10e. Street and Number				ancock	10f. Zip	Code 750				_		What Cou	ntry?	-
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hyerhan "natural", or Items 23a or 28a-f show int, the Medical Examinar must be notified at		202 Maryland A 11. Marital Status 1 Never Married 2 Mar 3 Wildowed 4 Divorced	12		2 XNo	1		lent of Hi	spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)			ck, White,	can Indian, etc.	
21215-0036 ad within 72 hours aft gjene. er than "natural, or er than "natural sami	Completed by	15. Deceden (Specify only highe Elementary/Secondary (0-12)	's Educa st grade o	tion completed) College (1-	-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done c	turina mos	t of work	ing	16b. K	lind of B	usiness/Ir		
ind 21 be filed wi tal Hygien d other th	Be	12. 17. Father's Name (First, Middle,	Last)	2		Seam	stres	S			e (First, Middle	, Maider			nufactı	ıre
Maryland 21215-0 td 2 should be filed within 72 ho th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical.	၉	George Hartz 19a. Informant's Name/Relations	nip <i>(Type</i>	, Print)					nd Numbe	er or Rur	Poplaw	er, City			Code)	
or Heal		Alan Pryor/Son 20a. Method of Disposition 1 Burial 2 □ Cremation		noval from S		Place of Dispo cemetery, crei	sition (Nam	ne of	-		Spring Date	-			own, State	
Baltimore, permit. Pages 1 ar Department of Hea Important: if item any injury or otha once.		4 □Donation 5 □ Other (S 21. ignature of Funeral Service	-	-1	Mt.	1	. Name and	d Addres	s of Facilit	•	1		Vest	Mair	Street	
		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complica only one	tions that ca	used the dea						P.A. H or respiratory a		ick,1	MD 21	750-036 Approximate Interval Between Onset and De	reen
Dur be	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	abc d	Due to (d	or as a conse	quence of):				7	qeeq	P			VU 917	
ecords, P.O. Box 687 law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230	1 Live bi	come of pregr rth 2 Fet ant at time of wn	aldéath 3□	Ectopic pre						23d. Dat Moi	te of delive	ery Day Ye	ar :
cords, P	þ	Part II. Other significant condition	ns contri	buting to de	ath but not re	sulting in the u	nderlying ca	use give	n in Part I.						ne cause of dea	
The The page	Completed										24a. Was auto perfo 1 Yes	psy ormed?	5	orior to co death?	psy findings av mpletion of cau	/ailable use of
of Vital F Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No				ER/Outpatien		are an area	r: 4 □ Nui	rsing Ho	me 5 Aresi	dence			y)	
Vision of Attending Property of Geath.	Certification;	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	ation		f Injury n, Day Year)	28b. Time of	М		at ? ′es 2⊡1	Vo _	28d. Describe					
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Cerif	4 Homicide determ	ned	buildin	g, etc. (Spec				-		28f. Location (City or To	wn, State)			9 <i>r</i> ,
the Hos	fedicai	(Check only 2 Medical one)	Examine	r: On the ba	sis of examin	owledge, death ation and/or in	restigation,	in my op	inion, deat	d place, th occurr	and due to the ed at the time,	date and	d place, a	and due to	the cause(s)	
To T To I	Σ	29b. Signature and title of certifie	=	4				License		57					Day, Year)	
5	7	30. Name and address of person	ATTE	EED,	40) -	1282	Print)	AK	Hi(1	12.HA	GEA	257	awi	v. M	0
Sta Registr	-	31. Date filed (Month, Day, Year)	00.4	32. Re	gistrár's Sign	ature	<i>P</i> •									

			State of Maryland / De 1- State Amend Item 24a per Dr., G82802/02/04db	partment of Health and N Pertificate of Death	nental Hygiei Reg.	ne 2004 02646
	Di		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		Hermine Sullivan		7 11	Day Year 3:40p M
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth
			Doctors Community Hospital	Lanham		Prince Georges
ì.	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye June 19,1	
	pur M		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits
	Aaryli I sho	ō				11∑Yes 2 No
	28a-	rect	Maryland Prince Georges Greenb 10e. Street and Number	elt 10f. Zip Code	10g	Citizen of What Country?
	3a or	Funeral Director	6110 Breezewood Ct. #103	20770		JSA
	ms 2	hera	11. Marital Status 12. Was Decedent Ever in U.S.	3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28a-f show appringing or other treumatic event, the Medical Exercities natalize notified at once.	þ	Amed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: Black
Ŏ	72 ho	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work	16b	. Kind of Business/Industry
2	thin 7	nple		e. DO NOT use retired)		
2	ygien ygien yer th	Co		essmaker		omens Clothing
Ē	be fill	Be	17. Father's Name (First, Middle, Last) Darrell Holloway (Son)		e (First, Middle, Maid	len Sumame)
3	d Mer narke	၉		Rositta		
Maryland	d 2 sl th and 7 is r			ailing Address <i>(Street and Number or Rur</i> 7 Lincoln Ave. Belt		
	1 an Heal Iem 2			THE STATE OF THE S		Location - City or Town, State
IO I	ages ant of it: If ii	1	I Bunal 2 Cremation 3 Premoval from State	orematory or other place) ood Mem Gardens 1-3	1-04 Ho	llywood Elevelle
Baltimore,	ortar injur		21. Signatura of Funeral Service License	22. Name and Address of Facility Aaron Cremation &]		llywood, Florida
m	Depariment of the part of the		Ment Goods	6107Miramar Pkwy M:	iramar, FL	33023
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respira ory arrest,	Approximate Interval Between
	Physician		disease or condition	we Head	tash	Onset and Death
1	/Medical Examiner		resulting in death) Due to (or a sconsequence of):		1	
ijģ	LAMITIME	U	Sequentially list conditions, b. Commonway	1 certen	arola	se yos
	led is	nlne	if any, leading to immediate Due to the as a consequence of); Cause (Disease or injury)	/		
	and and al-trar	Examiner	that initiated events c			
8760,	icate be executed physician and the burial-transit	dlcal				
Φ	ificat g phy as th	edle				
Вох	h cert andin use	M/LI	IF FEMALE: 23b. Was decedent pregnant 1	3 □Ectopic pregnancy		23d. Date of delivery
	The law requires that the death certif tie has been signed by the attending bage 2 should be detached for use a	Physiclan/Me	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month Day Year
о. О	at the by the	hy	9 DOKNOWN			
Ś	res tha igned be del	by	Part II. Other significan anditions contributing to death out not resulting in the	e underlying causeven in Part I.		o use contribute to the cause of death?
Record	w requir	Completed	terral period	hall	1 Tes	2 No 3 Probably 4 Unknown
Sec 2	e law has b	nple	makety mal	W. 100	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E E			10 00000 Trec	cour	performed?	? death? No 1 Yes 2 No
Viia	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Other	(Check only one)	
ō	2 ± a	2	1 ☐ Yes 2 ☑ No Compatient 2 ☐ ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim	TIGHT 3 DOA 4 I NUISING NO	me 5 Residence 28d. Describe how in	6 ☐Other (Specify)
0	ding Ph th. : After th funeral	tlon	1 Natural 5 Pending (Month, Day Year) Injui 2 Accident investigation			,ary coourned
Division of	Atter r dea ector by the	iflca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office		and Number or Rural Route Number,
á	s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify)	7	City or Town, Sta	afe)
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, do 2 Madiest Examiner: On the basis of examination and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	Withir To th comp	Me	29b Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
	-		under /	128920	2 1/	21/2004 .
		_	30 Name and address of person who completed cause of geath (flem 23a) (Type	pe, Print)	1 10	Freenbelt.
			SURINDER SNOT 7319	4 Hanover Ja	oKirthy. 1	10,20770 -
	Sta	te ar	31. Date filed (Month, Day, Year) FFB 0 2 2004	and I	9	

Physici	an	Decedent's Name (First, Middle, La				2. Date of Death Month	Day	3. Time of Dea
/Medic		George F. Thalw				JANUARY		
Examin	ier	4a. Fecility Name (If not institution, give 3306 KENYON AVENU			Town, or Location of Death		4c. County of	of Death
F		5. Social Security Number 6. 5			'IMORE CITY 1 Year If Under 24 Hrs.	8. Date of Birth		0.00
Funeral Director			the ope	13 Yrs. Months	Days Hours Min.	(Month, Day, Aug 23,	1960	9. Birthplace (State or Fo
ahow		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City L
1	ğ	MD	Ral	timore				1 ⊊ Yes 2
or 28a-f	rec	10e. Street and Number	Dai	10f. Zip	Code	10	g. Citizen of W	hal Country?
23a o	D E	3212 Overland Av	e	212	14		United	•
ltems .	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		ent of Hispanic Origin? (Spi ify Cuban, Mexican, Puerto		7	- American Indian,
or Re	F	1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 2		Rican, etc.)		, White, etc.
"natural", or edical Exam	d by	3 Widowed 4 Divorced	Year or Dates:	I Tes 2	No Specify:		Specify:	White
talica dica	Completed	15. Decedent's E. (Specify only highest gra	ducation ade completed)	16a. Decedent's Usua (Give kind of work	l Occupation k done during most of worki e retired)	na 1	6b. Kind of Bus	
han.	E G	Elementary/Secondary (0-12)	College (1-4or 5+)			(Constru	ction
and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f ahor sumatic event, the Medical Exander minal be notified at		12 17. Father's Name (First, Middle, Last,		General La		·=:		
Mental I arked of atic eve	Be				18. Mother's Name)
d Me nark natic	2	George F. Thalwi		405-14-15		A. Bongi		
T is i		Julie Brewer/Sis	*		(Street and Number or Rura			tate, Zip Code)
Department of Health and Men Important: If Item 27 is marke sny injury or other traumatic. once.	1 7	20a. Method of Disposition		3212 Over.	land, Baltimo			the au Touris Court
11 of 12 of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	etery, crematory or oti	her place)	Jan 28	oc. Location - C	city or Town, State
rtani njuni	1		1 CIIC	sapeake Cr	ematory :		Beltsvi	lle, MD
any ir		21. Signature of Funeral Garvice Liger	M00382	Crema	d Address of Facility tion and Fund Green Pasture	eral Alte	ernative	es
		23a. Part1. Enter the disease, or com shock, or heart failure. List only		Do not enter the mode	of dying, such as cardiac o	r respiratory arres	t,	Approximate
ysician		Immediate Cause (Final			licating Diabeti			Interval Betwee Onset and Deat
/ledical		disease or condition resulting in death)	Due to (or as a consequen		ircacing braneti	r veroacto	OSIS	
aminer			b					
=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ce of):				-11
rans	Examiner	that initiated events	c					
sician and burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):				
2 2	cal		d					
ing p	Med	IF FEMALE:	Vii					
attending phy I for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	r ath 3 ⊟Ectopic pre	gnancy		23d. Date	
the al	SCI	1 Yes 2 No	4☐ Pregnant at time of death 9☐ Unknown				Month	n Day Year
ed by the a	Phy							
		Part II. Other significant conditions of	ontributing to death but not resultin	ig in the underlying car	use given in Part I.		_	ute to the cause of death
should	ted					1 Tes	2 □ No 3	☐ Probably 4 ☐Unkn
has b	Completed					24a. Was an autopsy	24b. We	re autopsy findings avail or to completion of cause
page	5					performe	d? dea	ith? Yes 2□ No
= 5		25. Was case referred to medical examiner?			26. Place of Death			200 20110
his la	၉	1⊠ Yes 2□ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DOA	Other: 4 Nursing Hom	ne 5 ☐ Residenc	e 6x2Other	(Specify) AT SCEN
After this of	 	27. Manner of Death 1 □ Natural 5 □ Pending		_ Joiery		8d. Describe how		
the f	cat	2 Accident investigation 3 Suicide 6 Could not be	1/25/04 8:	30 a ^M	1 ☐ Yes 2X No	unknown		
irect by	Certification:	4 Homicide determined	building, elc. (Specify)	, farm, sireet, factory,		City or Town, S	State)	or Rural Route Number,
led i	ථ් 🏻		other residence			306 Kenyon	Avenue,	Baltimore,MD
To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	/sician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death occurred at and/or investigation, it	the time, date and place, and my opinion, death occurre	nd due to the caus d at the time, date	e(s) and mann and place, and	er as stated. I due to the cause(s)
o th		29b. Signature and title of certifier		29c.	License number	29d.	Date signed (A	Month, Day, Year)
		> Zahim	as ART		OCME			26, 2004
1	- 1	am.m.	06/					,
		30. Name and address of person who	ompleted enume of death the con-	a) (Toma D 1=0)				

		for State	State of Man	yland / Depa	artment o		Mental Hy	giene	
Physic	cian	Registrar Decedent's Name (First, Middle, Last ESTHER)			or Death	2. Date of De	ath Day Yee	3. Time of Death
/Med Exam	lical	4a. Fecility Name (If not institution, give	street and number)	TURKO		wn, or Location of Dea	Februa	4c. County of De	
		9704 Inaugural Wa	У			nersburg		Montgon	ery
Funera Directo		5. Social Security Number 6. Se 057–10–9848		n yrs. last birthday) 95 Yrs.	If Under 1 \ Months D	Year If Under 24 Hr Days Hours Mir	n. (Month, Da	th ly, Year) 9. B 4, 1908 Ne	irthpleca (State or Foreig Country)
and w.		Usual Residence of Decedent 10a. State 10b. County	10	C. City, Town or Lo	cation				10d. Inside City Limits
Maryli I-f aho	tor	Maryland Montgome			ersburg	7			1 √ Yes 2 No
or 288	Funeral Director	10e. Street and Number	1		10f. Zip Co	ode		10g. Citizen of What 0	Country?
s 23a	rail	9704 Inaugural W				20879		U.S.A.	
DEMINITION OF INTERPRISED A LAID-UNGO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 I e marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Exercites must be notibled at		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates:	'	Was Decedent f Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No irto Rican, etc.)	- 14. Race - Am Black, Wh Specify: Wh	ite, etc.
72 hou	ted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual C	Occupation	orkina	16b. Kind of Busines	
within me.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	done during most of w retired) -	orking	Own Home	
filed v Hygie other i	Be Co	17. Father's Name (First, Middle, Last)	·	1101	- ICMARCI		ame (First, Middle,	Maiden Sumame)	
wild be Mental Mental arked	To B	Louis		Resnikof	f	Fanny	7		
Alcar y 2 sho and 1 le ma rauma	1	19a. Informant's Name/Relationship (T)						er, City or Town, State,	Zip Code)
C, II 1 and Health Am 27 other t		Francine Hertz/ D			3 Chris		Court,	Boyd, Mary 20c. Location - City o	
ages ant of M: If it		1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cren Monte Fic Ceme	natory or other ore			St. Alban	s,
Datitimore, Maryjania 412.15-0030 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, tra Medical Even any only.		21. Signature of Funeral Service Licens	4	22	. Name and A	ddress of Facility Ro		New York Evans Fune e, Marylan	ral Home
		23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		vnestia					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a co						1
		Sequentially list conditions, if any, leading to immediate cause. Enter Undervin	Due to (or as a co	onsequence of):	theci	v.E.			Months
outed id ansit	Examiner	cause. Enter Under vin Cause (Disease or injury that initiated events		, , , ,					
ite be executed tysician and ne burial-transit	Exa	resulting in death) Last	Due to (or as a co	onsequence of):					
g physicas bas the b	dical		i						
attendin for use	by Physician/Medi	in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetel death 3	Ectopic pregn			23d. Date of de Month	olivery Day Year
hat the dod by the detached	hys	1 Yes 2 No 9 Unknown	9□ Unknown						
w requires that should be det		Part II. Other significent conditions con	ntributing to death but no	ot resulting in the ur	nderlying cause	e given in Part !.		bacco use contribute t 'es 2□No 3□P	o the cause of death? robably 4 DUnknown
I or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	Completed						24a. Was autop perfor 1 \(\text{Yes} \)	sy prior to	utopsy findings available completion of cause of
v v co ician: cartific ector,	Be	25. Was case referred to medical examiner?	lospital:			Other	ath (Check only o		
Phys or this aral dir	To To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatient		Other: 4 Nursing I		ence 6 Other (Spe	ecify)
nding ath. r: Afte	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury		Work? 1 ☐ Yes 2.2(No		on many occurred	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	et, factory, off	fice	28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
e Hospi 24 hour e Funer, letely fills	edical	29a. Certifier 1. Certifying Physical Constant C	sician: To the best of more: On the basis of exa and manner stated.	y knowledge, death amination and/or inv	occurred at the	he time, date and place my opinion, death occ	e, and due to the ourred at the time, o	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
To th Within To th compl	Me	29b. Signature and title of certifier				cense number		29d. Date signed (Mon	th, Day, Year)
e		> SATY W				4584	_5	rebruary	2nd 2004
6		30. Name and address of person who co			Print)	1 # 100	Rock	rule MI	20850
St Regist	ate trar	31. Date filed (Month, Day, Year)	327 Registrar's	Signature	eth)				

		1 - For State Registrar	State of Mary		artment of He <i>rtificate of D</i>			ene 200	14 0261
Physici /Medic		1. Decedent's Name (First, Middle, La Dekisale)			Taylor		2. Date of Death Month	Day Ye	4 10:34A
Examin 	er	4a. Facility Name (If not institution, given the Johnson Hopk) 5. Social Security Number 6. S	ex ZAge (In	yrs. last birthday)	4b City, Town, or L	ocation of Deat	. S. Date of Birth	4c. County of E	Birthplace (State or For
Director		Usual Residence of Decedent	X M 2□F 80			110013	9-27-2	23	Pa.
liffed at	ctor	Md : 10b. County	10	c. City, Town or Lo Balti					10d. Inside City Li
23a or 21	ai Dire	10e. Street and Number 2231 E. North Av	e.		10f. Zip Code 21213		10	g. Citizen of What USA	Country?
il', or Itams	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (S , Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A	merican Indian, /hite, etc. Black
nd ortygens. do other than "natural", or leams 23s or 28e-1 show event, the Modical Examiner must be notified at	Completed	15. Decedent's E. (Specify only highest gra	lucation	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ring most of wor	rking	6b. Kind of Busine	ess/industry
nd Mental Hygiene. marked other than matic event, the Mi	To Be Co	NA 17. Father's Name (First, Middle, Last) UNKN		N		8. Mother's Nar	ne (First, Middle, Ma		
8 8	F	19a. Informant's Name/Relationship (•		ng Address (Street an				e, Zip Code)
0 = 0		Lorriane Alexano 20a. Method of Disposition 12 Burial 2 Cremation 3 C 4 Donation 5 Other (Specific	Removal from State	Ob. Place of Dispo cemetery, crer	natory or other place)		Date 20	c. Location - City	5.
Department o Important: If any injury or once.		21. Signature of Funeral Service Licen	5000 Wan	22	mel Cem. Name and Address March F.H.	. East	Balti 1101 E.	undalk, More, Mc North Av	. 21202
ysician Medical aminer the prial-transit	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor	nsequence of):		e driv	or respiratory arres	t,	Approximate Interval Betwee Onset and Deat
by the atlending parached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
signe d be d	þ	Part II. Other significant conditions of	ontributing to death but no	t resulting in the ur	nderlying cause given	in Part I.		_	to the cause of death
e has age 2	e Completed	25. Was case referred to medical				***************************************	24a. Was an autopsy performe	d? prior t	autopsy findings avai o completion of cause ? es 2 \(\text{No} \)
si di	ertification: To Bo	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 X ER/Outpatien 28b. Time of Injury	Other: 28c. Injury a Work?	4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how		pacify)
ral Director:	O	3 Suicide 6 Could not be determined	building, etc. (Sp	pecify)			City or Town, S	State)	Rural Route Number,
within 24 hours and To tha Funaral Dis completely filled in	ledicai	one)	rsician: To the best of my iner: On the basis of examand manner stated.	knowledge, death mination and/or inv	occurred at the time, estigation, in my opin	date and place, ion, death occur	and due to the caus red at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
To	Σ	29b. Signature and title of certifier	ll m		29c. License n			Date signed (Mo	
Star	e	30 Tame and address of person who of 31. Date filed (Month, Day, Year) FFR 0 2 2004	Registrar's S	(Item 23a) (Type, I	Print)	Johns Hop	the Hope !	Bulthore	2, 2004 Mayland Zii

			For Amend Item 19a	per Fff, 682702	2702704dhbe	ertificat	t of H	lealth and	Mental Hy			02650
			Registrar 1. Decedent's Name (First, Middle, L	netl		Crincai	011	Dealit	2. Date of De	Reg. No.	E 0 0 -	3. Time of Death
	Physici	an	James Burton Ti						Month	Day		
	/Medic			L		4h Cihi	Tours	L continue of Con	Janua		County of Death	7:00 PMM
	Examir	er	4a. Facility Name (If not institution, g Gilchrist Cente			40. City,	rown, o	r Location of Dea Towson	un		altimor	
X					e (In yrs. last birthda	If Under	1 Year	If Under 24 Hr.	S. 9 Date of Ri			
40/05/	Funeral		410-05-4464	1 M2 2 □ F	8 7 Yrs.	Months	Days	Hours Min		y, Year)	9.16 GA	place (Stete or Foreign intry)
0	Director		Usual Residence of Decedent						Mai 1	0, 13	JIO GA	
100	/land	:	10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
	Man Fed	ţŏ	MD Baltir	nore	Baltimo	ore						1 ☐ Yes 2 No
2	ith the Marylar or 28a-f ehow	Director	10e. Street and Number			10f. Zip	Code			10g. Citi	zen of What Co	intry?
K	burs after death with the Maryland rel', or litems 23e or 28e-f ehow	0	5214 Daybrook C.	ir. Apt. 14	17	21	237			Uni	ted Sta	tes
90 P	death	Funerai	11. Marital Status	12. Was Decedent		3. Was Dece	dent of H	lispanic Origin? (Specify Yes or Norto Rican, etc.)	D-	14. Race - Amer	
8 "	or the same		1 Never Married 2 Married	Armed Forces?				Specify:	no Hican, etc.)	-	Black, White	, etc.
~	ours and	<u>\$</u>	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:		I L Tes	ZLESINO	<i>Зрвспу</i> :			Specify: Whi	te
7:0	within 72 hours after dea ene. than "naturel", or Items in Wedical Examiner in	Completed	15. Decedent's (Specify only highest g		(G	cedent's Usu	rk done	during most of we	orking		nd of Business/I	ndustry
5	r the state	idu	Elementary/Secondary (0-12)	College (1-4or	5+) life	. DO NOT u	se retired	1)		Inc	lustrial	
1 6	V 055	S	12		Lea	id-burr	er					
2 6	tal High	Be	17. Father's Name (First, Middle, La.						ıme (First, Middle		Sumame)	
£ 5	y so ould Men Men Marks Marks	2	Charles Burton						Leatherw			
Tiplan, James	ise, was yeared within the filed so that the filed so that the filed so that the filed so that the filed so that the filed with the filed so that the filed so the filed so the filed so the filed so the filed so the		19a. Informant's Name/Relationship Cynthia Tipton-Mair			_			Rural Route Numb	_		
0	T and 2 Health Health tem 27			norri-daugnte	20b. Place of Dis			Cir. A	pt. 147,			MD 21237
8	P T T T T		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	anomaton: c	rematory or c	ne or ther plac	(e)	Feb 2	20c. Lo	cation - City or 7	own, State
1. plan	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra gncs.		* 4 ☐ Donation 5 ☐ Other (Spec		Chesap			-	2004	Bel	tsville	, MD
(= å	Dermit Depar Impor		21. Signature of Euneral Service Lic	ensee /	08906	22. Name at Crem	atio	n and Fu	neral A	ltern	atives	
1	a dured		- Hau	w _	<u> </u>				res Driv		altimor	
	Physician		23a. Part1. Enter the disease, or co shock of heart failure. List on Immediate Cause (Final	ly one cause on each li	Consequence of):		9 or ayın	g, such as cardia	A Dacu	irrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	consequence of):			necese) Treat			moranas
	Examiner		0	b								
1		ner	Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury that initiated events		a consequence of):							
a	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c								
c	e exe		resulting in death) Last	Due to (or as	a consequence of):							
0220	S S S	Ical		d								
000	Joan Certifica eattending ph	Med	IF FEMALE:							1		
ć	ath ce	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic p		,		2	23d. Date of deli- Month	very Day Year
	the a	Sici	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of death	5 ☐ Other (sp	ecrfy)				Wild III	Suy Tour
	that the de ed by the detached	Physician/M	Part II. Other significant conditions	and the stine to doot b	unt mot sometime in the	n von dank in e		an in Dant I	220 Did	oba ese u	sa santributa ta	the cause of death?
_	signed de de de	b	Part II. Other significant conditions	contributing to death to	at not resulting in the	s anderlying (ause giv	eri iri Faiti.				bably 4 Unknown
2	v requires been sign should be	Completed									100 00110	Sacry 4 Gorikilowii
G G	ne law has b	npie							24a. Was	DSV	prior to c	opsy findings available ompletion of cause of
,		b							1 ☐ Yes	ormed? 22 No	death? 1 ☐ Yes	2 □ No
200	The Table has page	Ö						26. Place of De	eath (Check only	one)		11.3
1 to 1 to 1 to 1 to 1 to 1 to 1 to 1 to	cian: The entificate has ector, page	Be	25. Was case referred to medical examiner?	11			0.15					11-00110
Vital Doografic	Physician: The this certificate had director, page	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatio				4 Nursing	Home 5 Res		Other (Spec	4) 1-10> pre
L obsocial Document	ing Physician: The ing Physician: The Atter this certificate haveneral director, page	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	ıry 28b. Time	e of a	28c. Injur Wor	y at k?	Home 5 Res 28d. Describe		•	(x) [-TOS PICE
Labrace Design	tending Physician: The Beath. for: After this certificate he the funeral director, page	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat	28a. Date of Inju (Month, Da	y Year) 28b. Time Injur	of y y M	28c. Injur Wor 1	y at	28d. Describe	how injur	y occurred	
Vision of Visal Doctor	or Attending Physician: The law requires that the death certifica affer death. Iffer death. Director: After this certificate has been signed by the attending ph. in by the funeral director. page 2 should be detached for use as the control of th	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ıry 28b. Time	of y y M	28c. Injur Wor 1	y at k?	28d. Describe	how injury	y occurred	al Route Number,
you of observed letty to relative	pital or Attending Physician: The urus after death. eral Director: After this certificate hillied in by the funeral director, page	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide	28a. Date of Injuid (Month, Date of Injuid (Month, Date of Injuid	ury y Year) 28b. Time Injury Injury - At home, farm, c. (Specify)	of y M street, factor	28c. Injur Wor 1 y, office	y at k? Yes 2 □ No	28d. Describe 28f. Location (City or To	how injury Street and wn, State,	y occurred d Number or Ru	al Route Number,
description of Witch	Hospital or Attending Physician: The Set hours after death. Funeral Director: After this certificate hat filled in by the funeral director, page	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not determine 4 Homicide 1 Certifying	28a. Date of Injuid (Month, Date of Injuid (Month, Date of Injuid	28b. Tim. y Year) 28b. Tim. Injui jury - At home, farm, ic. (Specify) of my knowledge, dif examination and/o	of y M street, factor	28c. Injur Wor 1 y, office	y at k? Yes 2 No	28d. Describe 28f. Location (City or To	Street and wn, State, cause(s)	d Number or Ru	al Route Number,
de l'étail Donnée	o the Hospital or Attending Physician: The initin 24 hours after death. O the Funeral Director: After this certificate hompletely filled in by the funeral director, page	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injuid (Month, Date of Injuid (Month, Date of Injuid	28b. Tim. Injury - At home, farm, c. (Specify) of my knowledge, duf examination and/oated.	e of y M street, factor eath occurred investigation	28c. Injur Wor 1 y, office at the tin , in my o	yat k? Yes 2 No	28d. Describe 28f. Location (City or To	Street and wn, State, cause(s) date and	y occurred d Number or Rul and manner as place, and due	al Route Number, stated. o the cause(s)
obraced letty to recision	Hospital or thours afte Funeral Dir tely filled in	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injuid (Month, Date of Injuid (Month, Date of Injuid	28b. Tim. Injury - At home, farm, c. (Specify) of my knowledge, duf examination and/oated.	e of y M street, factor eath occurred investigation	28c. Injur Wor 1 y, office at the tin , in my o	yat k? Yes 2 No	28d. Describe 28f. Location (City or To	Street and wn, State, cause(s) date and	y occurred d Number or Rul and manner as place, and due	al Route Number, stated. o the cause(s)
Shrond Lativida	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injuid (Month, Date of Injuid (Month, Date of Injuid	28b. Tim. Injury - At home, farm, c. (Specify) of my knowledge, duf examination and/oated.	e of y M street, factor eath occurred investigation	28c. Injur Wor 1 y, office at the tin , in my o	yat k? Yes 2 No	28d. Describe 28f. Location (City or To	Street and wn, State, cause(s) date and	y occurred d Number or Rul and manner as place, and due	al Route Number, stated. o the cause(s)
observed to state of the state	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injuid (Month, Date of Injuid (Month, Date of Injuid	28b. Tim. Injury - At home, farm, c. (Specify) of my knowledge, duf examination and/oated.	e of y M street, factor eath occurred investigation	28c. Injur Wor 1 y, office at the tin , in my o	yat k? Yes 2 No	28d. Describe 28f. Location (City or To	Street and wn, State, cause(s) date and	y occurred d Number or Rul and manner as place, and due	al Route Number, stated. o the cause(s)
obracio di Mista di Constanti	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injunction be 28e. Place of Injuncting, et al. 28 aminer: On the basis of and manner st August Carrotte Ca	28b. Tim. Injury - At home, farm, ic. (Specify) of my knowledge, do if examination and/o ated. death (Item 23a) (Ty	e of y M street, factor eath occurred investigation	28c. Injur Wor 1 Urg., office at the tir, in my oc. Licens	yat k? Yes 2 No	28d. Describe 28f. Location (City or To	Street and wn, State, cause(s) date and	y occurred d Number or Rul and manner as place, and due	al Route Number, stated. o the cause(s)

/Med	ian	1. Decedent's Name (First, Middle, Las	st)		rtificate				2. Date of De	Day	Y Yes	3. Time of Dea
	ical	JULIA				<u> </u>	NT		JANUAR	4 2	9 200	4 11:06 1
Exami	ner	4a. Fecility Name (If not institution, give) DUHUS 140PK143 BAV	_	AL LENTER	1		Location of	Death		4c.	County of D	eath
Funeral		5. Social Security Number 6. S	,	n yrs. last birthday,	If Under 1	Year	If Under 2		8. Date of Bir	rth .	NA	Birthplece (State or For
Director		USUAT Residence of Decedent	□ M 21XF 69	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 2-28	ay, Year) -34		Country) Md.
how	_	10a. State 10b. County	10	Dc. City, Town or L								10d. Inside City Lin
28a-f	Director	Md. NA		Baltin								Y☐Yes 2☐
- O		10e. Street and Number 3336 Cardenas Av	_		10f. Zip C					10g. Citi	izen of What	Country?
ms 23	Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.		L213	panic Origi	n? (Spec	ify Yes or No)-	USA 14. Race - A	merican Indian,
"natural", or Itams 23a or 28a-1 show solical Examinar must be notified at	b	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Deceder If Yes, specify 1 ☐ Yes 2X		, Mexican, Specify:	Puèrto F	lican, etc.)		Black, W	
e 1	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual (kind of work DO NOT use	done du	ion iring most o	of workin	g	16b. Ki	nd of Busine	ss/Industry
Hygiene. ther than int, the M	Con	10th grade		Nurs	sing						Varies	
o do	To Be	17. Father's Name (First, Middle, Last) Cornelius		Trent			Ed:	ith	(First, Middle,	K	nowlan	
f Health and Meritom 27 is marke other traumetic		19a. Informant's Name/Relationship (7) Cheryl Trent	Daughter	3336	ng Address (S Carde	enas		, Ba	ltimor			, Zip Code) 213
0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, crei King Men	matory or othe	of er place)	_	Da -4-0				or Town, State OWn, Md.
Department important: I eny injury o		21. Signature of Funeral Servica Licen	wan.		2. Name and A larch F		,		Ba 1101 E	ltimo	ore, M rth Av	d. 21202 e.
Medical caminer			Due to for as a co			TION						1 days
sician and burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co									1 days
by the attending physician and ached for use as the burial-transit	Ca	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a co	onsequence of): onsequence of): regnancy Fetal death 3	⊒Ectopic pregi] Other (speci	nancy				2	3d. Date of d Month	
gned by the attending se detached for use as	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	b. Due to (or as a co	onsequence of): onsequence of): regnancy Fetal death 3 [e ol death 5 [Other (speci	nancy rfy)					Month se contribute	elivery Day Year to the cause of death?
ss been signed by the attending 2 should be detached for use as	Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	b. Due to (or as a co	onsequence of): onsequence of): regnancy Fetal death 3 [e ol death 5 [Other (speci	nancy rfy) se given	in Part I.		1 🗆 Y 24a. Was autop perfor 1 🗆 Yes	obacco us /es 2 [an usy rmed? 2 2 No	Month se contribute No 321 24b. Were a prior to death?	elivery Day Year to the cause of death? Probably 4 Unkno
ss been signed by the attending 2 should be detached for use as	o Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	b. Due to (or as a co	onsequence of): regnancy Fetal death 3 e ol death 5 ot resulting in the unit	Other (specified)	nancy fy)se given	in Part I. 26. Place of		1 Yas autop perform Yes Check only on	obacco us (es 2 an sy rmed? 2 A No	Month se contribute No 321 24b. Were a prior to death? 1 Ye	elivery Day Year to the cause of death? Probably 4 Unkno autopsy findings availa completion of cause of
ss been signed by the attending 2 should be detached for use as	To Be Completed by Physician/Medical	Cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	b. Due to (or as a co	onsequence of): regnancy Fetal death 3 e ol death 5 ot resulting in the unity 2 ER/Outpatien 28b. Time of	Other (special of special of spec	nancy rfy) se given Other: Injury a Work?	in Part I. 26. Place of 4 ∐ Nursi	ng Home	1 🗆 Y 24a. Was autop perfor 1 🗆 Yes	an sy med? 2 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Month se contribute No 321 24b. Were a prior to death? 1 Ye	elivery Day Year to the cause of death? Probably 4 Unkno autopsy findings availa completion of cause of
itler death. Director: After this certificate has been signed by the attending in by the tuneral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown Part II. Other significant conditions conditio	b. Due to (or as a cold. 23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown ontributing to death but not the second of the	onsequence of): onsequence of): regnancy Fetal death 3 e ol death 5 ot resulting in the unity of the content of the	other (special number) of the special number) of the special number (special number) of the spec	nancy fy) se given Other: Injury a Work? 1 □ Ye	in Part I. 26. Place of 4 ☐ Nursii t	ng Home	24a. Was autop perfoil 1 Yes Check only or 5 Resid	des 2 an an an an an an an an an an an an an	Month se contribute No 321 24b. Were a prior to death? 1	elivery Day Year to the cause of death? Probably 4 Unkno autopsy findings availa completion of cause of
itler death. Director: After this certificate has been signed by the attending in by the tuneral director, page 2 should be detached for use as	al Certification: To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cold. 23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown Intributing to death but not Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye) 28e. Place of Injury	onsequence of): regnancy Fetal death 3 e ol death 5 ot resulting in the unit of the control of the cont	other (special and and and and and and and and and and	nancy fy) se given Other: Injury a Work? 1 □ Ye	in Part I.	ng Home 28 28	24a. Was autop perfoil 1 Yes Check only or 5 Resided. Describe h	an symmed? 2 Dr No ne) dence 6 fow injury	Month se contribute No 3201 24b. Were a prior to death? 1 Ye Other (Sp	elivery Day Year to the cause of death? Probably 4 Unkno autopsy findings availa p completion of cause of the cause of t
death. stor: Afler this certificate has been signed by the attending r the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cold. 23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown ontributing to death but not the state of Injury (Month, Day Yebridan, etc. (S	onsequence of): regnancy Fetal death 3 e ol death 5 ot resulting in the unit of the control of the cont	other (special decision of the special decision of the	other: Injury a Work? 1 Ye	in Part I. 26. Place of 4 Nursi: t ss 2 No	28 28 28 28 28 28 28 28 28 28 28 28 28 2	24a. Was autoperformed by the second of the	an symmed? 2 Dr No ne) lence 6 low injury litreet and n, State) tate and late Month se contribute No 321 24b. Were a prior to death? 1 1 Ye Other (Sp	elivery Day Year to the cause of death? Probably 4 Unkno autopsy findings availa completion of cause as 2 No ecify) Rural Route Number,	
itler death. Director: After this certificate has been signed by the attending in by the tuneral director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cold. 23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown ontributing to death but not the state of Injury (Month, Day Yebuilding, etc. (S)	onsequence of): regnancy Fetal death 3 = oldeath 5 =	other (special and and and and and and and and and and	nancy fy) se given Other: Injury a Work? 1 Ye ffice	in Part I. 26. Place of 4 Nursi: t ss 2 No	28 28 28 28 28 28 28 28 28 28 28 28 28 2	24a. Was autoperformer autoper	an symmed? 2 Dr No ne) lence 6 low injury street and n, State) state and late Month se contribute No 321 24b. Were a prior to death? 1 1 Ye Other (Sp	elivery Day Year to the cause of death? Probably 4 Unkno autopsy findings availa p completion of cause as 2 R No ecify) Rural Route Number, as stated. as to the cause(s)	

			1 – For State Registrar	State of Mar		artment of F			giene Reg. No. 20	04	02652
	Dhusisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ith	Уеаг	3. Time of Death
	Physici /Medio		William L. Uhler					January			10;30 A.M.
	Examir	er	4a. Facility Name (If not institution, give 6000 Glen Falls I			4b. City, Town, o	r Location of De Cerstown		4c. County	of Death timor	e
	Funeral		5. Social Security Number 6. Se		in yrs. last birthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of Birth	2		ce (State or Foreign
	Director	П		2M 2□F 77	Yrs.	Months Days	Hours *M	in. June 2	7°41926	Re1	sterstown
	pu *		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	eation				100	d Jasida Obellinia
	Aaryla F sho	ō				terstown				100	d. Inside City Limits 1 ☐ Yes 2 ☐ X90
	28e-	rect	Md. Balti	rilore	Keis	10f. Zip Code			10g. Citizen of W	hat Countr	
	3e or	<u></u>	6000 Glen Falls I	Road			21136		-	USA	, .
	within 72 hours after death with the Maryland ane. then "neturel; or Items 23e or 28e-f show the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race	- American	
36	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 ☐ XNo If Yes, Give	I .	1 ☐ Yes 2 ☐ No	Specify:	erto rucari, etc.)	Specify:	white, et. Whi	
21215-0036	hours turel'	Completed by	3 Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		A dent's Usual Occup	ation	1		AA11.T	
5.	n ne	plet	(Specify only highest gra-	de completed)	(Give	kind of work done of the NOT use retired	during most of v	vorking	16b. Kind of Bus	sinessyinau	stry
212	d with giene er the	E O	6th Grade	College (1-4or 5+)	S	elf Emplo	oyed		Truck	Drive	r
	2 should be filed withir and Mental Hygiene. is marked other then eumetic event, the M	Be (17. Father's Name (First, Middle, Last)					lame (First, Middle,	_	3)	
<u>ya</u>	should tind Ment marked umetic	2	Elmer Uhler				Marg				
Maryland	12 sh h and 7 is rr treur	-	19a. Informant's Name/Relationship (7 Annette Smith	урө, Print) Niece				Rural Route Number Coss Junti		State, Zip C 2262	_
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show eny injury or other treumetic event, the Madical Examinar must be notified at ODGS.	1 8	Annette Smith 20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1		20c. Location - (
ē	Pages nent of int: If it		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify	+	cemetery, crer Finksbury	matory or other place g Cemeter			inksbur		
Baltimore,	permit. F Departme Importer eny injur	1	21. Signature of Funeral Service Licen			2. Name and Addres	- 2/2	11824 Re		-	
ä	Depa Impo		Sam B &	Kine	E1	ine Fune	ral Home	e Reister	stown,	MD	21133
>	Physician		23a. Part1. Enter the disease, or compensors, nor heart failure. List only distributed in the condition of t	ilications that caused thone cause on each line.	e death. Do not ent	er the mode of dyin	g, such as card	iac prespiratory arr	est	C	opproximate interval Between Onset and Death
	/Medical Examiner		and death)	Due to (or as a c	consequence of):	1		0	8)		
		ē	Sequentially list conditions, if any leading to immediate	b. Due to for as a c	onsequence of					-	
/	uted d ansit	Examiner	Sequentially list conditions, it any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	cate be executed ohysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a c	consequence of):						
8760,	hysici	dlcal		d							
9	ding p	0	IF FEMALE:	23c. If yes, outcome of	orognanov						
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 [4 Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Da	
, P.O	that the sed by detact	y Ph	Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use contril	oute to the	cause of death?
rds	quires n sigr uld be	ed by	المراه المراكب	tes w	tille	می		1 □ Ye	s 2VINo 3	B 🗆 Probab	ly 4 Dunknown
တ္တ	aw requir ts been si 2 should	Completed						24a. Wasa	n 24b. W	ere autopsy	y findings available letion of cause of
æ	The tate ha	mo:						autops perforr 1 ☐ Yes 2	ned? de	lor to comp eath? ∃Yes 2[
ita	icien: The lav certificate has ector, page 2	Be	25. Was case referred to medical examiner?					eath (Check only on			
of V	hysic this ca	ို	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatien		4 🗆 140131119	Home 5 Peside			
n C	Jing F	lon	27. Manner of Death S ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	28c. Injury Work	rat ⟨? Yes 2 □ No	28d. Describe ho	ow injury occurre	d	
Division of Vital Records,	Attendir death.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	286. Place of injury	- At home, farm, stre		res 2 🗆 NO	28f. Location (St	reet and Number	or Rural R	Poute Number,
Ö	s after el Direc ed in by	Cert	4 Homicide	building, etc. (Specify)			City or Town	i, State)		
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page	Medical	29a. Certifier (Check only one) Certifying Phylogen Medical Example (Check only one)	rsician: To the best of niner: On the basis of ex and manner stated	:amination and/or inv	occurred at the tim restigation, in my op	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, d	ause(s) and man ate and place, ar	ner as state and due to th	ed. e cause(s)
	To t To t	Σ	29b. Signature and tile of certifie			29c. License	number	2	9d. Date signed	(Month, Da	y, Year)
	10				w,	1	33(6	2	1	29	04
	10		30. Name and address of person who co	. Shedter	1167	Print) Carab)	er P.1	a Van	frstere) w	75015
	Sta Registr	-	31. Date filed (Month, Day, Year)	2004 Registar's	Signature	Special		\	V		

	1	For State Registrar	S	tate of	Maryland		artmen <i>tificate</i>			ınd M	lental Hy	giene Reg. No	$ ^{\prime}$ U	04	0265
Physician /Medical	1	1. Decedent's Name (First, Midd Robin Ly		art				•			2. Date of De Month Jan	ath 30 Da	y 200	Year	3. Time of Death
Examiner	r é	la. Facility Name (If not institution 643 Johahn Dr	ive					stmi	nste:	r			. County o	roll	
uneral rector		5. Social Security Number 216-88-7325 Usuel Residence of Decedent	6. Sex 1 M		7. Age (In yrs. Ia 41	Yrs.	Months	Days	Hours	Min.	8. Date of Bi	th y, Year)	53	9. Birthp Cour Mary	place (State or Foreignty) Land
arked other than "naturel", or Itame 23s or 28s-1 show stic event, the Medical Examinar must be cotified at To Be Completed by Funeral Director		10a. State 10b. Count Maryland Carr			'	.Town or Lo								1	0d. Inside City Limits
to retilied		10e. Street and Number 643 Johahn D	rive				10f. Zip	Code 2115	57			10g. Cit	izen of W		ntry?
marked other than "naturel, or itema 23e or 28e-1 ehow matic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Dy runera	11. Marital Status 1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rned 1	Vas Deced Imed Ford Yes : Yes, Give Year or Da	2 📆 No	1	Was Deced f Yes, spec	rfy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	ocify Yes or No Rican, etc.)	>-		, White,	ean Indian, etc.
t, the Medical E	Jubiered	15. Decede (Specify only high) Elementary/Secondary (0-12)		n n <i>pleted)</i> College (1-	4or 5+)	life. L	lent's Usua kind of wor DO NOT us ffice	k done d e retired)	uring most	of workii	ng		ind of Bus	siness/Ind	dustry
To Be Co	D	17. Father's Name <i>(First, Middle</i> Frederick W. U			<u> </u>				18. Mothe		(First, Middle	, Maiden			<u> </u>
rtrauma		19a. Informant's Name/Relation David Unkart —				19b. Mailin 2106	g Address Sterl	(Street a	nd Numbe Ct. I	rorRura Lamps	Route Numb	er, City o	2107	State, Zip	Code)
eny injury or other traumatic once.	2	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (tate ce	ace of Dispo	natory or of	her place	´ 1		ate 2,200		ocation - C	•	
eny injur		21. Signature of Funeral Service		D111011	3 3703	E.C. 32	Name and khard	Address	s of Facility	Cha	pel P.	A.	Ma	0urg	· FIG.
ician dical		23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	it only one ca	els on ea	used the death. ch line.	Do not ente	er the mode	of dying	, such as	cardiac o					Approximate Interval Between Onset and Death
s the burial-transit	Lyain	Sequentially list conditions, if any, leading to immediate cause. Either Industrying Cause (Disease or injury that initiated events resulting in death) Last	b c d	`	or as a conseque										
letached for use as Physician/Mec	y sicial vine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Live bir	ome of pregnan th 2 Fetal on that time of dea	death 3	Ectopic pre			_			23d. Date Mont		ry Day Year
p p	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Part II. Other significant condit	ions contribu	ting to dea	ath but not resul	ting in the un	iderlying ca	use give	n in Part I.			obacco u			e cause of death?
for. page 2 should be Completed I		25. Was case referred to medica	1								1 Yes	sy med? 2 No	pri	ere autopior to con eath?	osy findings available apletion of cause of 2 No
by the funeral directrical dir	2	examiner? 1	Hosping 20 gigation not be	a. Date of (Month) أ أسادة أ أسادة le. Place of building	Day Yeer) O C U Injury - At hong etc. (Specify)	28b. Time of Injury Lu Know (28 1 M	Other Bc. Injury Work' 1 Y	r: 4 □ Nur at	sing Hom 2 lo	8f. Location (S City or Tox	dence now injur	y occurred i N d Number	he or Rural	ad Route Number,
he Funer pletely fill edical	200	29a. Certifier 1 Certifyi (Check only one) 2 Madical	Examiner:	n: To the bas	pest of my know sis of examination or stated.	ledge, death on and/or inv	occurred a estigation,	it the time in my opi	e, date and inion, deatl	niace a	nd due to the	cause(s)	and man	ner as sta	atod
comp		29b. Signature and title of certific	Len	LN	γ			License	1924	-		_			Dey, Year)
State	1	30. Name and address of person Levice P. Hendle 31. Date filed (Month, Day, Year FEB 0 1	igen Jr.	M () 30	of death (Item : 973 Maugistrar's Signatu	wheste	Print)					2110			

			1 - For Registrar	State of Maryla	nd / Dep		Health and M	Mental Hyg	giene	e. 14 02651
	Physic		1. Decedent's Name (First, Middle, Last,	VENABLE				2. Date of Dea Month	th Day V	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give		<u>-</u>	4h City Town	or Location of Death	1	4c. County of	
755	Examil	ier	NORTHWEST +				11		Balt	
ia.	Funeral Director		5. Social Security Number 6. Sec		last birthday) Yrs.	Randal If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year) 9.	Birthplace (State or Foreign Country)
	/land		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	death with the Maryland ima 23s or 28s-f show if Luast be restiffed at	ector	Marylan Baltino	R	Wood					1 ☐ Yes 2 No
	23e or	al Dir	33 17 KERRY A	CAO		10f. Zip Code	207	1	0g. Citizen of Wha	· ·
	nii. Pages 1 and 2 should be filed within 72 hours after death with the Marylar nariment of Heatilth and Mental Hygiene. ordrant: if Item 27 is marked other than "natural", or Itema 23e or 28e-f show on other treumatic event, the Madical Examinet rust be retified at injury or other treumatic event, the Madical Examinet rust be retified at a.	by Funeral Director		12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 → No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2☐No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
- - - -	"natura	leted	15. Decedent's Edu (Specify only highest grade	cation	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Busin	
N	filed withir Hygiene. other than ont, the M.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	TAX	DO NOT use retire			sey Em	ployEss
Maryland	i be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)	ole	•		18. Mother's Nam	e (First, Middle, M	Maiden Surname)	
ج	d Me d Me nark natio	2	GEORGE VENAL				MABEL	100		
	and 2 sl lealth an m 27 ls r her treur	-	19a. Informati's Name Relationship (Ty)	Doughter	33/7	ng Address (Street	and Number or Rur	al Route Number, 1561 fin	City or Town, Sta	te, Zip Code) J/207
baltimore,	of He of He of Hen if Item	1	20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ R		Place of Dispo cemetery, crer	sition (Name of matory of other place		Date .	20a Langtian City	os Tours State
Ě	permit. Pages 1 ar Department of Hea Important: If Item eny injury or othe once.		' 4 □Donation 5 □ Other (Specify)	1	Tckson	Consta	21	1/091	CROWE.	Virginia
D D	permit. Departr Importe eny inje		21. Signature of Funeral Service License	fe L:	5	Name and Addre	S of Facility C/	19 KM	- HAMAIN	MANUAL NUME
J	nysician		23a. Part1. Enter the disease, or complied to the control of the c	cations that caused the deale cause on each line.	th. Do not ent	er the mode of dyir		or respiratory arre	est,	Approximate Interval Between Onset and Death
,000	ate be executed Medical was and wisicien and he burial-transit	cal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enier Underrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	juence of):					
.O. BOX 68	ine law requires that the death certificate the has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn; 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c	death 3	Ectopic pregnancy Other (specify)	1.		23d. Date of Month	delivery Day Year
, co.	w requires that been signed b should be deta	b	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	iderlying cause giv	en in Part I.			e to the cause of death? Probably 4 □Unknown
		Completed						24a. Was an autopsy perform	prior death	autopsy findings available to completion of cause of 1? Yes 2 19 No
VILA	certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			26. Place of Death	(Check only one	9)	
5	this aidi	2	1 Yes 2 SoNo	1 Manpatient 2	ER/Outpatient		4 LI Nuising Hor		nce 6 Other (S	ipecify)
5	th. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Wori M 1	γat <br Yes 2 □ No	28d. Describe how	w injury occurred	
	after death. Director: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre			28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
9110	o the hospital of Attending within 24 hours after death. To the Funeral Director: Attence completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Physical (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurre	and due to the car ed at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)
4	Mithin Forth	Me	29b. Signature and title of certifier		-	29c. License	number	29	d. Date signed (Mo	onth, Day, Year)
-	/			- mo		25	54352	j	ANUARY	76 2004
	5		30. Name and address of person who cor				CEA TODO		, ,,	7 11 79 4
	Sta	te_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	-	et road	ICTN DA	LSTOWA	J MD	21133
	Registr		FEB 0 2 2004	Production of	Land	e.				

DHMH 17 Rev 1/2001

ORIGINAL

			1- For Amend Item#9,p	State of Marylan erFH,G828,2/9/2004,	d / Depa gap <i>Ce</i>	artment of H	ealth and	Mental Hy	giene Reg. No. (2004	02655
	d _a	8	Decedent's Name (First, Middle, I	Last)				2. Date of Dea	ath		3. Time of Death
	Physici /Medi		NILZH	VoGsL				Month	Day 24	300H	8:40 AM
	Examir		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Deal			ounty of Death	
			STELLA MARIS	HOSPICE		Timon	nui		BE	Win	or in
	Funeral		5. Social Security Number 6	. Sex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h v. Year)		place (State or Foreign htryPennsyIvania
Carrie	Director		317-30-3090	1 M 25 F 77	Yrs.			JULY 4	1936	0,0	010010
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cib	/. Town or Lo	ocation		1		1	10d. Inside City Limits
	sho	ō	Deal and Davis		2 00	1 1100					1 ☐ Yes 2 ♣ No
	28a-1	Director	10e, Street and Number	12015	1 द्रारार	10f. Zip Code			10a Citizo	n of What Cou	
	with a or	à	Ci i il la ci co	500m Q 01	`	Tor. Zip Code	n		Tog. Citizer	11 OI VVIIat Cou	nd y r
	leath	Funeral	11. Maritat Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of Hi	Spanic Origin? (9	Specify Yes or No-	14	Race - Ameri	can Indian
10	r Her	Ξ	1 ☐ Never Married 🏖 Married	Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		Btack, White,	
980	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2∰ No	Specify:		Sį	pecify:	7.T.F.
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or items 23a or 28a-f show the Mudical Executive to the frediffied at	Completed	15. Decedent's		16a. Dece	dent's Usual Occupa	ation	dina	16b. Kind	of Business/In	dustry
21	thin 'e	ple	(Specify only highest of Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life.	DO NOT use retired))	rking			
2	filed withi Hygiene. other then	5	87RS.		43.5	17 Koon			MONI	Gomza	H WARDS.
Maryland	be file id oth even	Be	17. Father's Name (First, Middle, La				18. Mother's Na	me (First, Middle,	Maiden Su	ımame)	
yla	should be and Mental is marked o	မ	7002 Por	PITRUSH			707	A ME	RAG	10	
0	and and is m		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ri	ural Route Numbe	r, City or T	own, State, Zip	Code) SIUS
	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other then "natural; or items 23s or 28s-f show or other traumatic event, the Michael Expurient unable muffled at		112212	627	lidp	HAVENT	ERM	KOHO H	RRY	HALL	1ARYLAND
ore	Pages 1 nent of H int: If ite iry or ott		20a. Method of Disposition SS Burial 2 ☐ Cremation 3	- ~		sition (Name of matory or other place	e) JAC	Date	20c. Local	tion - City or To	own, State
Baltimore,	Pa ant ant		'4 □Donation 5 □Other (Spe		chino	00/jus/	ERY! DO	400	LYSK	1 SLLIV	MRYLAND
Sall	permit. Departr Imports any inju		21. Signature et Euneral Service Lic	censes	522	Name and Address	s of Facility	FUSING	Ciss:	~	,213.34
-	go E a o		THOK I M	di:	3	AK 00 88	RFORD (GOOD H	3KV	Will.	ARILANO
44			23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that caused the death	. Do not ent	er the mode of dying	g, such as cardia	c or respiratory ar	rest,	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ALZHEIMER'	S DISI	EASE					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						
	LAGIMICI	_	Sequentially list conditions,	b	District State of		<u> </u>				
7	be sit	liner	cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or se's coneaqu	ньпес от:						
	and I-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):						
8760,	cate be executed physician and the burial-transit	E		000 10 (0) 43 4 00/13040	once on.						
87	physi the	dlcai	•	d						-	
×	The law requires that the death certifi tte has been signed by the attending to page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnar	nev						
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			230	 Date of delive Month 	Day Year
o.	the de	yslo	1 ☐ Yes 25 No 9 ☐ Unknown	9☐ Unknown	ratii 3L						
4	that the de led by the a detached		Part II. Other significant conditions	s contributing to death but not resu	alting in the u	nderlying cause give	n in Part I.	23a. Did to	bacco use	contribute to the	ne cause of death?
Records,	sign d be	d by			-	, , ,		1 🗆 Y	es 2 🗆 N	lo 3□Prob	nably 4 Dunknown
ŏ	w require been si should t	Completed						24- 146-			F . C
Rec	has pe 2	m d						24a. Was a autop perfor	sy	prior to co death?	psy findings available mpletion of cause of
<u>=</u>								1 🗆 Yes	2 🖾 No	1 ☐ Yes	2□ No
Vital	Physician: this certific	o Be	25. Was case referred to medical examiner?	Hospital:	vedi - p	Othe		ath (Check only or		-	
of		 -	1 ☐ Yes 2 ₹ No 27. Manner of Death	1tnpatient 21 28a. Date of Injury	ER/Outpatien 28b. Time of	I 3L DOA	4 PNursing F	fome 5 Resid			y)
on	ding Ph. h. After thi funeral	th P	1 Naturat 5 Pending 2 Accident investigat	(Month, Day Year)	tnjury	Work	? ∕es 2 ⊡No				
Division	Attending r death. ector: Alter by the fune	flca	3 Suicide 6 Could not	be Geo Blace of Injury At he	me, farm, str			28f. Location (S	treet and N	umber or Rum	I Route Number,
Ö	after death after death Director: /	Certification:	4 Homicide	building, etc. (Specify)	,,,		City or Tow	n, State)		
	To the Hospital or Atwithin 24 hours after d To the Funeral Direct		29a. Certifier 🕊 Certifying	Physician: To the best of my know	viedge, death	occurred at the tim	e, date and place	and due to the o	ause(s) an	d manner as si	ated
	e Ho 124 h e Fui letely	edical	(Check only 2 Medicat Ex one)	aminer: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my op	inion, death occu	rred at the time, o	late and pla	ice, and due to	the cause(s)
	omp	Me	29b. Signature and title of certifier	M -		29c. License	number	2	9d. Date s	igned (Month,	Day, Year)
	0/		1	1-1		104	372	S	1/2	27/0	4
	4		30. Name and address of person wh	no completed cause of death (ttem	23a) (Type.	Print)	J		•		•
	U		TARIQ MAHMOOD,		, .	ALLEY ROA	D TIMON	NIUM, MD	21093	3	
4	Sta	te	31 Date fited (Month Day Year)	22 Pagistras Cignot	1150	0					
	Registr	ar	FFR	0 2 2004 States	e str	Sports.					

HELEN VOGEL JANUARY 24, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygiene 0 0 1	02656
Certificate of Death Reg. No.	02001

Physician /Medical Examiner
Funeral Director

1 - For State

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Hegistrar					intoute of i	J04111	H	ig. No.		
1. Decedent's Name	e (First, Middl ACEY	b, Last)		Wright			2. Date of Deat Month	Day	Year	3. Time of Death
		n, give street and nu		WEIGHT		Location of Deatl	Januar	26 4c. Count	2004 v of Death	8:00 P ^M
200							· .	NA		
5. Social Security N		Hospital 6. Sex	7. Age (In yrs. la	st birthday)	Baltimor If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birtho	place (State or Foreign
216-08-0	0809	½ □M 2□F	33	Yrs.	Months Days	Hours Min.	12-21-	70°	Md.	ury)
Usual Residence of 10a. State	Decedent 10b. County		10c City	Town or Loc	ation	-			1	Od. Inside City Limits
Md.	1	IΑ	Too. Oily,	Balti						1 ☑ Yes 2 ☐ No
10e. Street and Nun					10f. Zip Code		11	0g. Citizen of	What Cour	**
5109 Ken		h Ave.			212	12		USA	***************************************	,.
11. Marital Status		12. Was Dec	edent Ever in U.S	. 13. W	Vas Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Rac	ce - Americ	
1 Never Marri	ied 2 Mar	ned 1 ☐ Yes	2X No		Yes, specify Cuba		o Hican, etc.)		ick, White,	
3 Widowed	4 Divorced	If Yes, G Year or I	Dates:	'	☐ Yes 🎇 No	Specify:		Specil	^{fy:} Bla	ack
(Spec	15. Deceden	nt's Education est grade completed,		(Give k	ent's Usual Occup	during most of wor	rking	16b. Kind of B	Business/Inc	dustry
Elementary/Seco GED	ondary (0-12)	College	1-4or 5+)		OO NOT use retired sportatio	,		Trans	, Too	rio
17. Father's Name	(First. Middle.	Lasti		TLans	portatio		ne (First, Middle, A) T.C
Michael	,	,	Wrigh	+		Norma			Reed	
19a. Informant's Na	ame/Relations	ship (Type, Print)	WL 1911		g Address (Street		ral Route Number,	-		Code)
Michael	Wright	Father		8201	Duck Cre	ek Dr.,	Raleigh,	N.C.	276	516
20a. Method of Disp			Cer	ce of Dispos	sition (Name of place	e)	Date	20c. Location	- City or To	own, State
1 □ Burial 2 ['4 □ Donation		3 □Removal from Specify)	State		int Cem.		-04	Balti	imore	. Md.
21. Signature of Fu	ineral Service	Licensee		22.	Name and Addres	s of Facility	Balt	imore,	Md.	21202
P (3)	lac	lus W	anen		larch F.H	. East	1101 E	. Nort	h Ave	2.
shock, or hea Immediate Cause (irt failure. List (Finat	r complications that t only one cause on	caused the death. each line.		the mode of dying		-2.5	ost,		Approximate Interval Between Onset and Death
disease or condition resulting in death)	on	a. Due to	(or as a consequ	7	Alot r	000100				
Conventially lies on	an elikion e	b								
Sequentially fist con if any, leading to im- cause. Enter Under	nmediate		(or as a conseque	ence of):						
Cause (Disease or that initiated events resulting in death) I	S .	C. Due to	(
, , , , , , , , , , , , , , , , , , ,		Due to	(or as a conseque	ence or):						
		d							111	
IF FEMALE: 23b. Was decedent	t orognant	23c. If yes, ou	itcome of pregnan	су				23d Da	ate of delive	ary
in the past 12	months?		birth 2 Fetal on nant at time of dea		Ectopic pregnancy Other (specify)				onth	Day Year
9 Unknown		9□ Unkr	nown							
Part II. Other signif	ficant conditi	ons contributing to	death but not result	ting in the un	derlying cause give	an in Part I.	23e. Did tob	acco use con	tribute to th	ne cause of death?
							1 🗆 Ye	s 2 100	3 Prob	ably 4 Unknown
							24a. Was ar		Were auto	psy findings available mpletion of cause of
							perform	ned? □ No	death?	2□ No
25. Was case refer examiner?	red to medica	u				26. Place of Dea	th (Check only one		-	
				R/Outpatient	3□ DOA Oth	ar: 4 🗆 Nursing H	ome 5 Reside			y)
XXYes 2	th	.9	of Injury oth, Day Year)	28b. Time of	28c. Injun Worl	(? //	28d. Describe ho	w injury occur	rred	+
27. Manner of Deat	5 🗌 Pendir		16-04	19.19	,	Yes 2 No	200 Leastier (St	ecc	2110	/ D
27. Manner of Death 1 Natural 2 Accident	5 ☐ Pendir investi 6 ☐ Could	not be	a of Indiana. At home	ia iarm sira	et, factory, office		28f. Location (Str	State)		Houte Number,
27. Manner of Deat	investi	not be 28e. Plac	e of Injury - At horn ling, etc. (Specify)	0 - 5	0 0		210 T K	enitud	cuth 3	37-0
27. Manner of Deatl 1 Natural 2 Accident 3 Suicide 4 Homicide	investi 6 Could detern	not be nined 28e. Plac build	ding, etc. (Specify)	de of	cesider	Ce date and place	Baltin	1 m	anner as st	RC .
27. Manner of Death 1 Natural 2 Accident 3 Suicide	investi 6 Could determ	not be 28e. Plac build ng Physician: To the Examiner: On the limits of the property of the pro	e best of my know	de F	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	and due to the ca	use(s) and ma	anner as st	tated. o the cause(s)
27. Manner of Deatt 1 Natural 2 Accident 3 Suicide 4 Shomicide	investi 6	not be 28e. Plac build ng Physician: To the Examiner: On the and mai	e best of my know	de F	occurred at the tin estigation, in my of	oinion, death occu	, and due to the ca rred at the time, da	use(s) and ma	anner as st and due to	the cause(s)
27. Manner of Deati 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (uneck only one)	investi 6	not be 28e. Plac build ng Physician: To the Examiner: On the and mai	e best of my know	de F	estigation, in my o	number	, and due to the ca rred at the time, da	use(s) and mate and place,	anner as st and due to ad (Month,	Day, Year)
27. Manner of Deatt 1 Natural 2 Accident 3 Suicide 4 Shomicide 29a. Certifier (Unack only one) 29b. Signature and	investi 6 Could determ 1 Certifyin 2 Medical	not be 28e. Plac build ng Physician: To the Examiner: On the and mai	e best of my know pass of examination and stated.	de of ledge, death on and/or invo	29c. License O.C.M	number	, and due to the ca rred at the time, da	use(s) and mate and place,	anner as st and due to ad (Month,	o the cause(s) Day, Year)

State Registrar

FEB 0 2 2004

DHMH 17 Rev 1/2001

5

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 30, 2004JANUARY Scott Andrew Weiss **Physician** 1:23 P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL CO 326 KINGSBERRY DRIVE ANNAPOLIS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Qay, Year) | Nov. 14, 1967 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months **Funeral** 36 tXXM 2□ F 213-06-1142 Missouri Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show the Medical Examinar must be notified at Yes 2□No Director Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number tams 23a or United States 21401 326 Kingsberry Drive Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2001No If Yes, Give hours after Never Married 2 Married

3 Widowed 4 Divorced 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2\text{No Specify: White þ Year or Dates: "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15 Decedent's Education 72 (Specify only highest grade completed) d 2 should be filed within h and Mental Hygiene.
7 is marked other than "r Flementary/Secondary (0-12) College (1-4or 5+) Own Business Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Caroline Mertin Arden Oscar Weiss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Caroline E. F. Weiss-Sloan 326 Kingsberry Drive Annapolis, MD 21401 Pages 1 and 2 ment of Health a ent: If Item 27 is ury or other trai 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2XXCremation 3 Removal from State Feb. 2,2004 Baltimore, MD Metro Crematory permit. Page Department. Importent: It any injury o * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue Annapolis, MD 21401 23a Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failing. List only one cause on each line. Approximate Interval Between Onset and Death Im ediate Cause (Find disease or condition resulting in death) Shotgun wound -oval Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 X No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 24a. Was an certificate has b irector, page 2 s autopsy performed? 1 Yes 2 No Hospitel or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) SC 1/1E Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No funeral dir ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification; Pm After Injury subject shot lumselt 5 Pending 1 Natural Found 1:30 1 ☐ Yes 2 X No the Funeral Director: Af investigation Found 1-30-04 2 Accident
3 Suicide
4 Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 326 Kings berry 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home Annapolis hiD 🖂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 JANUARY 31, 2004 OCME m.D hi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 LI in it LING

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Morth Boan Y2")2004

ORIGINAL

Registrar's Signature

81681

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month 4b. City, Town, or Location of Deeth 4c. Co Weeks D. 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Baltimore Mercy Hospital if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 M XIXF Yrs. 216-42-7905 04 30 ΜĎ 44 59 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Essex 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code U.S.A. 13 Valley Arbor Ct. 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? ☐ Yes 21 No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐NO Specify: Specify: Black 3 Widowed 4 Divorced Yeer or Dates 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4yrs Elementery/Secondary_(0-12) 12th grade Teacher Assistant Chimes 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Newsome Joseph Darby Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 19a. Informant's Name/Reletionship (Type, Print) 133 North Bend Road apt 1C, Baltimore, Md Anthony Weeks-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/31/04 Randallstown, 21. Signature of Funeral Service Licensee March F H West 4300 Wabash Ave, Baltimore Md 21215 23a Part. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart unifure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ノトう cance Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 2 No 24b. Were autopsy findings 24a. Was an eutopsy performed? available prior to completion of cause of death? 1 Yes 2 100 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at page.

Ruth

10a. Stete

MD

Directo

Funeral

2

Completed

physician and s the bunal-transit Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, USB as attending p ed by the a signed by t d be detact After this certificate has been situneral director, page 2 should To the Hospital or Attendis within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death.

Examine Physician/Medical ģ Completed Be ို

Certification:

Medical

25. Was case referred to medical examiner?

D

State Registrar

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1/ Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature end title of certifig

29c. License number

29d. Date signed (Month, Day, Year) 26 2004

30 Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

Rischera 30651 DEVID 200 42. Registrar's Signature 31. Dete filed (Month, Day, Year)

Baltimore

26. Place of Death (Check only one)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 2004 3:00 A M Ricky L. Wood /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Edgewater Anne Arundel 1637 Elkridge Drive If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | April 18,1948 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Sex. ADM 2□F **Funeral** 55 223-64-4150 Virginia Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic svent, the Mudical Examiner must be notified at 1 ☐ Yes 2 🛣 No Funeral Director Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21037 USA 1637 Elkridge Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: 1968–69 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Technician Computers 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If item 27 is marked otherly injury or other traumatic even Joselle Barnes Robert Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn D. Wood/ Wife 1637 Elkridge Drive, Edgewater, MD 21037 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory Edgewater, MD 1-28-04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home but Hilliles 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** allers /Medical Due to (or as a consequence of): Examiner talle Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medicai use as the IF FEMALE: 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year Pregnant at time of death 5 Other (specify) o detached 9 Unknown been signed by the should be detach نه 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 → No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this After thi funeral 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural To the Hospins within 24 hours after dearn.

The Funeral Director: After the funeral birector. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28e. Place of fnjury - At home, farm, street, factory, office building, efc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3306 Culles 30. Name and address bf person who completed cause of death (Item 23a) (Type, Print) Rd Stell Annapolis ins 21401 Harris 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 2 Registrar

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** JANUARY 2:55 FM ANNA M. WELLING 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔼 F 219-28-4355 Director 8/25/1933 70 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel; or Itams 23a or 28a-f show the Medical Examiner must be coulded at 1 ☐ Yes 2 X No MD BALTIMORE PARKVILLE Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2908 PLACID AVENUE 21234 USA Funerai 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify by Specify: WHITE 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lith and Mental Hygiene. 27 is marked other then r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental HARRY AULD ANNA SCHATZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rtment of Health ar SON DOUGLAS R. WELLING 2908 PLACID AVENUE BALTIMORE, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State = 5 12 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Important: If any injury o * 4 ☐ Donation 5 ☐ Other (Specify) 2/6/2004 MORELAND MEM. PARK HILLENDALE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL INFARACTION DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine The law requires that the death certificate be executed and that initiated events resulting in death) Last physician arts the burial-tr Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Day Year signed by the a 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. as been signal 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 X No certificate ha 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA his 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2-01-04 D30263 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 ERANCIS KHOO. 7601 M. D 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 19 Registrar FFB 0 2 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** RANCE an /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 20%F Yrs. Director Usual Residence of Decedent death with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23e or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at lymore 1 ☐ Yes 2 ANo Funeral Director 10g. Citizen of Whet Country? 10e Street and Number 10f Zip Code 508 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Nidowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is merked other than "r telephone company Elementery/Secondary (0-12) College (1-4or 5+) 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be oleman Peges 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City of Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Eeh 2 20a. Method of Disposition 20c. Location - City or Town, State ō 1 SBurial 2 □ Cremation 3 □ Removal from State 4 □ Donetion /5 □ Other (Specify) 2004 22. Name and Address of Facility EVAIC 21. Signature of Funeral/Service/Licensee FURLAGE Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21334 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner to (or as a consequence of Examiner eral Director. After this certificate has been signed by the ettending physician and filled in by the funeral director, pege 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 XNO 3 Probably 4 Unknown 1 Yes þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1□Yes 20 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ဥ 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deeth Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital of within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated.

| Continue of the desired of the cause of the Medical 29a. Certifier 29c. License number 29b. Signature end tittle of certific 29d. Date signed (Month, Dey, Year) DJ3115 January 29 2004 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Partula MO 21234 mo 8400 Walth Jef Londona 31. Dete filed (Month, Day, Year) 32. Registrer Signature State Charles ! Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 10e, 14, 17, 18, 19a, b, 20a, b, c. 22per Ft. Int. / Yerb, G828, 02/02/04dhb RegistraMEND ITEM #30 PER DVR G827 1/23/04 Sterrificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death TACQUELYNE Martina WILSON **Physician** 1:594 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Randallstown <u>Baltimore</u> 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Pennsylvania 1 ☐ M 2 💢 F 35 Yrs. 189-64-0755 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Director MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3450 Carriage Hill Circle #203 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: Never Married 2☐ Married 1 ☐ Yes 2X No Specify: White Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) customer service rep insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stanley Wilson Stanleigh Wilson Lorraine Purnell Laraine Purnell 19a. Informant's Name/Relationship *(Type, Print)* Laraine Wilson Lorraine Wilson/mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6713 Second Morning Court Columbia, MD 21045 20b. Place of Disposition (Name of cametery, crematory or other place)
Metro Crematory Inc. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/22/04 Baltimore, MD `4 □Donation SMOther (Specify) in state 21. Signature Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Grenation Society of MD, Inc., 299 Frederick Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEMO BRADE E HOURS Due to (or as a consequence of): HROM BUCYOPENIA Security is tour differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine HOZDIM BOCYNDEMC PURPURY 1010pmthe resulting in death) Last Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISGRO GR 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 or Attending Physicien: this Director:

Funeral

Director

in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

death

be filed within 72 hours after data Hygiene. Id other then "natural", or Item

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event 90xg.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

director, After thi within 24 hours a

To the Funere! I

completely filled the

> State Registrar

Medical

Devolu

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) January 3th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMASWAMY LYENGAR RANGARAJAN NORTHWEST HOSPITAL RANDALLSTOWN MD 31. Date filed (Month, Day, Year)

FEB 0 2 2004

4 - Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature To the same

			1 - For State Registrar	State of Maryla		artment rtificate			•	giene Reg. No. 20	04 02664
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) EDITH 4a. Facility Name (If not institution, give s	MICHN	ER	4b. City, 3	Γown, or L	ocation of [2. Date of De Month	Day 14	Year 3. Time of Death
	Funeral Director		NORTHWEST HOSPITA 5. Social Security Number 212-09-6999		rs. last birthday) 90 Yrs.	+		STOWN If Under 24 Hours		BALTI	MORE 9. Birthplace (State or Foreign Country) MD
	Maryland a-f show	tor	Usual Residence of Decedent		City, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ter death with the Marylan Items 23a or 28a-f show iter must be notified at	Funeral Director	10e. Street and Number 904 PAINTED POST 11. Marital Status	ROAD 12. Was Decedent Ever in	US 13	10f. Zip		2120		10g. Citizen of W	hat Country? U.S.A American Indian,
0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show ideal Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:		1 ☐ Yes 2	No K	Specify:	1? (Specify Yes or No Puerto Rican, etc.)	Specify:	white, etc.
121215-0036	d within jiene. r than "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use AGEMEN	k done dur e retired)	ing most o			DEPT. STORE
Maryland	ed fa	To Be	17. Father's Name (First, Middle, Last) DAVID 19a. Informant's Name/Relationship (Ty,	pe Print)	PEAR			ANNE	Name (First, Middle,	KI	RSCHENBAUM
-	1 and 2 Health a om 27 is thar tran		B. DEBRA WICHNER 20a. Method of Disposition	/ DAUGHTER		PAINTE	D PO		AD - BALTI	MORE, ME	
Baltimore,	permit. Pages Department of important: If it in eny injury or o		1 M Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	В	ETH TFI	LOH CE 2. Name and	METE	of Facility		ISON & BF	AWN, MD
	Physician		23a. Part / Enter the disease, or complication of the complete		eath. Do not ent	ter the mode	of dying,	such as ca		rest,	Approximate Interval Between Onset and Death
8760,	/Medical executed whisician and hysician and hysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons Due to (or as a cons	equence of):						
P.O. Box 68	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	otal death 3	□Ectopic pre □ Other (spe				23d. Date Mont	of delivery th Day Year
	w requires that the been signed by the should be detache	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying ca	use given	in Part I.			oute to the cause of death?
Vital Records,	The law ate has t page 2 s	e Completed	25. Was case referred to medical					C Dia	1 ☐ Yes	rmed? de 200 1	ere autopsy findings available for to completion of cause of lath? Yes 3 No
of	Phys this raldii	To B	examiner?	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other: c. Injury at Work?	4 🗆 Nursir	Death Check onl o		
Division	vital or Attending urs after death. ral Director: After lied in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)	eet, factory,	office		City or Tow	m, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one) 2/ Medical Exemin	ician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death	vestigation, i	n my opini	on, death o	occurred at the time, o	date and place, an	d due to the cause(s)
1	V Viit	-	0	meala mo		0		1410		Jahunzy	28 h, 2004
7	Sta Registr	te ar	30. Name and address of person who col	32. Registrate Sig	RAI	MADE				33 .	

27. Manner of Death

Certification: To

After hours after death. in by t Medical

Division

To the Hospitel within 24 hours a (Check only 29b. Signature and title of certifier,

1 Natural 2 Accident

3 ☐ Suicide

4 - Homicide

State Registrar

28b. Time of

28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

29c. License number O.C.M.E

2XXMedicef Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 11, 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

3:35 P ^M

(State or Foreign

Yes 2 No

Year

4 Unknown

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) FEB 0 2 2004

5 Pendina

investigation

6 Could not be determined

3. Registrar's Signature

28a. Date of Injury (Month, Day Year)

			Please 1	Type or Print in Black Inc			
			For State	State of Maryland / Depa	artment of Health and N rtificate of Death	nental Hygiei	2004 02666
			Stete Registrar		uncate of Death	Reg.	3. Time of Death
	Physicia /Medic		Decedent's Name (First, Middle, Last Harris Lamar Alle	n	4h City Tours as Longting of Double	January 1	Day Year 5, 2004 0605 a.m. 4c. County of Death
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		
	Euparal		Harford Memorial 5. Social Security Number 6. Se		Havre de Grace If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Harford 9. Birthplace (State or Foreign
	Funeral Director			M 2□F 67 Yrs.	Months Days Hours Min.	(Month, Day, Ye February 2	20, 1936 Alabama
	ryland show	_	10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2XXNo
	Be-1s	Director	Maryland Ceci	1 Conow		100	Citizen of What Country?
	with the	ë	10e. Street and Number		10f. Zip Code	1 17	
	ns 23	era	922 Dr. Jack Road 11. Marital Status	12. Was Decedent Ever in U.S. 13. \	21918 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		Inited States 14. Race - American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-f show empty injury or other treumatic event, the Mardical Examination at an another and once.	by Funeral	1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	1 X Yes 2 □ No 1954 to	If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 🗓 No Specify:	Rican, etc.)	Black, White, etc. Specify: White
- Q	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	(Give	dent's Usual Occupation kind of work done during most of work	cina .	. Kind of Business/Industry
7	ithin 19.	ap.	Elementary/Secondary (0-12)	College (1-4or 5+) Superv	DO NOTuse retired) Visory Oridance Tr	aining	
7	iled w tygier ther ti		12 17. Father's Name (First, Middle, Last)	4 Speci		e (First, Middle, Maid	Government
and	d be find he ed of	Be c	Woodroe Allen				,
Maryland	should nd Me mark mark	၉	19a. Informant's Name/Relationship (T)	vpe, Print) 19b. Mailir	Mate D ng Address (Street and Number or Rui		ty or Town, State, Zip Code)
∑	nd 2 :		Karin Allen/Spouse	922	Dr. Jack Road, Co	nowingo. M	Maryland 21918
ē,	s 1 au if Hea item othe		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Date 20c	. Location - City or Town, State
E	Page nent c int: If		1 🕅 Burial 2 □ Cremation 3 □ I 1 □ Donation 5 □ Other (Specify)	Removal from State West Nott	200	ary 20, 4 (Colora, Maryland
Baltimore,	permit. Departn Importe eny inju		21. Signature of Funeral Service Lio-15			rouch Fune	eral Home
<u> </u>	89 E 2 9		Juli & l				East, Maryland 21901
	Physician	8	shock, or heart failure. List only of Immediate Cause (Final		er the mode of dying, such as cardiac		Approximate Interval Between Onset and Death One work
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence of):	nucarcinung of 10	719	one wille
	Examiner		Sequentially list conditions,	b			
A	p #	iner	if any, leading to immediate	Due to (or as a consequence of):			
(be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c			
,09	sician buria	a		ď			
687	ificate g phy: as the	edic		U			
О. Вох	The law requires that the death certificate I ate has been signed by the attending physi page 2 should be detached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Δ.	that the		The second secon	entributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
rds	w requires been sign should be	ed by	cerebrovascular	accident		1XYes	2 No 3 Probably 4 Unknown
of Vital Records,	The law re cate has bee page 2 sho	Completed	Deep Vein Thrumbe	osis ofleg		24a. Was an autopsy performed	
ta		a	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 ☑ th (Check only one)	NO 1 1 165 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Ϋ́	S S =	To B	examiner?	Hospital: Impatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing H	ome 5 🗆 Residence	e 6 □Other (Specify)
o uoi	nding Phy ath. r: After thi e funeral o		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time o Injury	f 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how in	njury occurred
Division	al or Atteractor Director	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospitel or Attending Pr within 24 hours after death. To the Funerel Director: After it completely filled in by the funera	Medical C	29a. Certifier Check only 2 Medicel Exem	yicien: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	, and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	within To the	Me	29b. Signature and title of certifier	۸	29c. License number	29d.	Date signed (Month, Day, Year)
			> peasent In	when mo	20004 8050		15/04
	1241		30. Name and address of person who cores hant Shukla	completed cause of death (Item 23a) (Type.	Print) # 400 Abeld	igen mo	2100
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 6 200	32 Registrar's Signature	, service		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar-Amend Item#26perVFRBALG8282/25/04 Excertificate of Death Reg. No 2 0 1 4 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear **Physician** 2:00 a^M 13 2004 Jan RAY CLARENCE BARNARD /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 15990 Maryland Highway Garrett Swanton
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 7 192 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1₽M 2□F Yrs. 76 Maryland Director 216-22-6891 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show show 1 ☐ Yes 2 ☐ vNo MD Directo Garrett Swanton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "neturel", or Items 23e or 3091 Chestnut Grove Rd 21561 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 25 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Bementary/Secondary (0-12) Paper Industry Westvaco 9th Grade othar 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be tment of Health and Mental Howard Barnard 7 is markac traumatic Florence Duckworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a /daughter 15990 Maryland Hwy Swarton Md 21561 Debbie Henderson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Barnard-Henderson 1/15/04 Cemetery 5 permit. Page Department i Important: fi any injury o Swanton, Md 22. Name and A dress of Facility 21. Signature of Funeral Seprice Licensee Boal Funeral Home, 111 Church St Westernport, Md 21562 am Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SARCOMA OSTEDGENIC FOUR MOINTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): .O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HTPURTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 1 ☐ Yes 2 ☐ No 1 Yes 208No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Darghter's Other: 4 Nursing Hom This idence 6 Other (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 ☐ Accident Injury 5 ☐ Pending death. narat Director: A filled in by the fu investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

JAMET R. 31. Date filed (Month, Day, Year)

Ollos

JAN 13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOEN M.D.

2004

32. Registrar's Signature

(068 NATIONAL HALHWAY

Annal D

29c. License number

D33417 (MARYLAND

29d. Date signed (Month, Day, Year)

LAVALE, MARILAND

JANUARY 13, 2004

21502

			Please I	Obstace Manuage						
			For State Registrar	State of Maryland	•	rtificate of			- Z 1111 ta	02668
			Registrar 1. Decedent's Name (First, Middle, Last)		- 00	rimeate or	Death	2, Date of Death	g. No.	3. Time of Death
	Physici	an	Florence Viola					January	Day Year	8:29 PM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat		4c. County of Deat	
	Examili	eı	Washington Count			Hagei	rstown		Washin	ngton
-,	Funeral		Social Security Number 6. Sec.	7. Age (in yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs			hplace (State or Foreign
	Director		217-56-0925	³ M ¾√√ 78	Yrs.	William Suy	1100.0	0ct.22,1	925 Penn	sýlvania
	pu 🛊	}	Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or L	ocation				10d. Inside City Limits
	eho eho	5	Maryland Washir		•	Williams	enort			1 ☐ Yes 2 📉 No
	28s-i	Director	10e. Street and Number	191011		10f. Zip Code	эрог г	10	g. Citizen of What Co	ountry?
	72 hours after death with the Maryland Insturat; or ttems 23s or 28s-f ehow disal Examiner must be motified at	٥	10516 Honeyfield	Rd.		2	1795		l.	ISA
	death ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.		Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No-	14. Race - Ame Black, Whit	ncan Indian,
9	or ite	Ē	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes 2 ☑ No		to mean, etc.)	Specify:	
5-0036	ours iral',	Completed by	3 Widowed 4 Divorced	Year or Dates:						White
5-(72 h natu	ete	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	rking	6b. Kind of Business/	Industry
2121	within ene.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	Homemake			Hom	20
CA	Hygie Hygie ther		17. Father's Name (First, Middle, Last)			nomemake	7	me (First, Middle, M	HOIT aiden Sumame)	ie
ano	d be antal cod o	To Be		Blair			Eliza	beth	Carpente	er
Maryland	should nd Men marke matic	F	19a. Informant's Name/Relationship (T)		19b. Marii	ng Address (Stree			City or Town, State, 2	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28s-f show appringnt or other traumatic event, the Medical Examiner must be notified at once.		Olive Robinson - S	Sister	1051	6 Honeyf	ield Rd.	Williamsp	ort, Maryl	and 21795
ē,	S 1 al f Hea item othe	1 3	20a. Method of Disposition	20b. P	lace of Disp	osition (Name of matory or other pl			0c. Location - City or	
E	Page nent o nt: If ry or		1 X Burial 2 □ Cremation 3 □ F 1 4 □ Decation 5 □ Other (Specify)	temoval from State			Ch.Cem.1-	16-04 M	ercersburg	,Pennsylvani
Baltimore,	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral Service Ligens	6	O ₂	sborne 4F4	unerfacility Ho			21795
Ö	Depa Impo any ii		Day ECSI		4:	25 S. Coi	nococheag	ue St.Wil	llamsport,	Maryland
	S 18		23a. Fatt. Enter the disease, or composhock, or heart failure. List only o	ications that caused the death	. Do not en	ter the mode of dy	ring, such as cardia	c or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Tochem.	c 130	nel	DISEA	Se		Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequ	uençe of):	1000	DISEL	6.		//
13	Examiner		Suquentially list conditions	Mesenter	7	1e-12	1000	20011		
	D is	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	Jence of):					
	and I-tran	хап	that initiated events resulting in death) Last	c	uence of):					
.09	te be executed ysicien and ie burial-transit	calE								
687	certificate iding phys ise as the	g		d						
Box (that the death certificate ed by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	livery
B	death atte	ciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		□Ectopic pregnan □ Other (specify)	cy		Month	Day Year
0	that the o	hys	9 Unknown	9□ Unknown						
ď.	res that th igned by be detach	by P	Partil. Other significant conditions co	ntributing to death but not resu	ulting in the	underlying cause o	given in Part I.	23e. Did tobi	acco use contribute to	
rd		ed t	12 Newsatol	E DITTIV	ITLS	·		1 🗆 Yes	s 2.27No 3.∏Pr	robably 4 Unknown
000		Completed						24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
R	The laste has page	E						perform	ed? death?	2 □ No
ita	sician: The law certificate has b rector, page 2 s	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)	
<u>_</u>	Physician: this certific ral director,	2	1 Yes 2 No		ER/Outpatie	HIL 3 DOA		-	nce 6 Other (Spe	ocify)
Division of Vital Records,			27. Manner of Death 1 ■Natural 5 ■ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	W		28d. Describe ho	w injury occurred	
sio	Attending r death. sctor: Alter by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				☐Yes 2☐No	204 Legation /Ctr	ant and Number of D	usal Route Alumbas
įΣ	or At fter of jirect in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		treet, factory, offic	θ	City or Town,	eet and Number or Ri State)	urar noute rvumber,
٦	pitst ours a erel [Ce	29a. Certifier 1 Certifying Phy	vsician: To the best of my kno	wledge des	th occurred at the	time date and place	e and due to the on	use(s) and manner as	s stated
	To the Hospitsi or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical		iner: On the basis of examina and manner stated.						
	o the	Me	29b. Signature and title of certifier	0/1.			nse number		d. Date signed (Mont	th, Day, Year)
	->-0		> Plus T.	Hely MA	7	DOC	2652	3 11	TUDANT!	13.2004
	.7		30. Name and address of person who o	ompleted cause of death (Ifen	23a) (Type	, Print)			10 110	-/-/
2	\		11120 T. Del	SIOVESS!	97	11110	REPLL	AL CAMPU) KULL	104,100
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	perked	•	146 5/25	1000, K	12

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JANUARY 12 3:51 A M JACK **McCLELLAN** BEARD 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. BALTIMORE CITY JOHNS HOPKINS BAYVIEW MEDICAL CENTER 8. Date of Birth (Month, Day, Year)
MARCH 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Min. 1⊠M 2□F Yrs 220-26-5250 78 MARYLAND **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir then "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21713 8115 MAPLEVILLE ROAD U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 X Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working It Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 STEEL WORKER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental is marked MARY DEVONA EYLER JOHN ALLEN BEARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if itam 27 to 22 BITTERSWEET DRIVE, HAGERSTOWN, MARYLAND 21740 HELEN E. DEAVERS/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 5 Other (Specify) REST HAVEN CEMETERY 1/16/2004 HAGERSTOWN, MARYLAND 21. Signature of Fi ice Licensee 22. Name and Address of Facility 7606 Old national Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hear7 /Medical Due fo (or as a consequence of) Examiner 10 5 15 Sequentially list conditions, if any, leading to immediate cause. Lits underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a la consequence of) Examiner The law requires that the death certificate be executed and f-tran physician ar Due to (or as a consequence of): Physician/Medical as esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant atten for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 2 🗆 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this After thi funeral of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 25Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death neral Diractor: A filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after To the Hospitel within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 John Eckman Eastern 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 5 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

o.

Division of Vital Records,

			riease	ype or Print							•		•		
			For State	State of Ma	ryland					na me	-	-	2001	000	7.0
			Registrar			Cer	TITICAT	e of D	eatn			Reg. No	2004	3 44 3	IU
	Physici	an	Decedent's Name (First, Middle, Last,							2	. Date of De Month	ath Day	y Year	3. Time of Dea	ith
	/Medic	_	Terry Lee	BALS	LE	Υ					JAN	1.		1405	М
	Examin	er	4a. Fecility Name (If not institution, give				4b. City,	Town, or L	ocation of	Death		4c.	County of Dea		
	•		Washington Cour					agers		Alles I -			Washin		
М	Funeral		5. Social Security Number 6. Sec	F37 -		st birthday) Yrs.	If Under Months		Hours	Min. NI.	Date of Bird (Month, Da OV • 25	th y, Year)	9. Bir	thplace (State or For ountry)	reign
3.22	Director		219-44-4485 Usual Residence of Decedent	2UF 5	/	113.				LV	ov. 25	, 1:	ино пав	erstown, N	ענאַ
	land	Ì	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Lir	mits
	Mary	ō	PA Franklir	n	Gr	eencas	tle							1 □ Yes 2 2	ΔNο
	the 288	Je C	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What C	ountry?	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at	by Funeral Director	415 Hykes Road					1722	5			US	3Δ		
	ms 2	Jera		12. Was Decedent Ev Armed Forces?	er in U.S	S. 13. V	Vas Dece			in? (Speci	ty Yes or No can, etc.)		14. Race - Am		
ထ	after or Ite	Ē	1 Never Married 2 Married	1. Yes 2 □ No		i	r Yes, spe⊲ I⊡ Yes			Puerto Hi	can, etc.)		Black, Whi	te, etc.	
8	ral'.	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		'	I L Yes	245 NO	Specify:				Specify:	white	
2 2	72 honatu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	lent's Usua kind of wo	al Occupati rk done dui	on ring most	of working	,	16b. K	ind of Business	/Industry	
2	ithin Men	de la	Elementary/Secondary (0-12)	College (1-4or 5+		life. L	DO NOT us	se retired)		3		1	1		
7	ygier ygier her ti		12			llia I I I	tenar				F:		spital		
ind	be first H dot	Be	17. Father's Name (First, Middle, Last)	-				1			First, Middle,		Sumame)		
$\frac{2}{5}$	Mer Marke	ို	George J. Bals					-			McClea				
Maryland 21215-0036	12 sh and rs un		19a, Informant's Name/Relationship (Ty	,									r Town, State,	Zip Code)	
_	1 and 4ealth		Kathy E. Balsley 20a. Method of Disposition	wife	20b. Pi					encas	stle P		225 ocation - City or	Town State	
סר	in of l		1 Burial 2 □ Cremation 3 F	lemoval from State	i	metery, cren									
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		* 4 ☐ Donation 5 ☐ Other (Specify)		Gree	en Hil				1/20/		Way	nesboro	PA 17268	3
Ba	permi Depa Impo any ir		Signature of Funeral Service Licens	1	,									eral Home	_
22			23a Part 1 Enter the disease or comple	Joe S									ncastle	PA 17225	>
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or immediate Cause (Final	ne cause on each line					30011 03 0	, a 7		1031,		Interval Between Onset and Death	า h
	Physician /Medical		disease or condition resulting in death)	a. Co		rjul	magge	city	ar	revi				runtes	5
	Examiner			Due to (or as a	consequ	ence of):	11 1	- 0	7).	// - / *	1			1. 2.	
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	ence of:	e ca		10	fire	ner (_		remed	
	uted Insit	E	Cause (Disease or injury	6 17	0 6	47 6	rite	u, c	dise	028_	-			nunita	,
,	exect n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequ			8							
760,	ate be executed sysician and he burial-transit	call													
89	leath certificate attending phy I for use as the														
Вох	n cert andin use	N/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	pregnar		le						23d. Date of de	livery	
m	deatle atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at ti			Ectopic pr Other (sp						Month	Day Year	
Ö	that the de ned by the a detached f	hys	9 Unknown	9□ Unknown											
Division of Vital Records, P.O.	Attending Physician: The law requires that the death certifical st death. st death. et death. by the attending phy the attending phy the inneral director, page 2 should be detached for use as the funeral director.	by Physician/Med	Part II. Other significant conditions con	ntributing to death but	not resu	lting in the ur	nderlying c	ause given	in Part I.		23e. Did to	obacco u	ise contribute to	the cause of death	?
ord	en si ould I	ed	dishete.								101	res 2)	⊠No 3□P	obably 4 Unkno	own
900	law re as be 2 sh	Completed	hyperten	acin							24a. Was		24b. Were a	topsy findings available completion of cause	able
ď	The ate h page	E O	J T								perfò	rmed? 2X No	death?	2□ No	
ita	artifica ctor.	Be	25. Was case referred to medical examiner?					2	26. Place	of Death (Check only o		1		
<u>~</u>	hysic his ce I dire	10	1 ☐ Yes 2 → No	lospital: 1 Inpatient	27	R/Outpatien	t 3□ DC	Other:	4 🗌 Nur	sing Home	5 ☐ Resid	dence	6 □Other (Spe	cify)	
ם	ng P	ë	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	2	8c. Injury a Work?	t	28	d. Describe h	now injur	y occurred		
Sio	eath. or: A	cati	2 ☐ Accident investigation				М		s 2 N						
$\frac{1}{2}$	l or Att after d Direct I in by	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At hor (Specify)	ne, farm, stre	et, factory	, office		28	f. Location (S City or Tox			ıral Route Number,	
	urs al			1						ī					
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier Certifying Physical Check only one)	sician : To the best of ner: On the basis of e	xaminati	vledge, death on and/or inv	occurred estigation	at the time, , in my opin	date and io <mark>n, deat</mark> h	place, and occurred	d due to the a at the time,	cause(s) date and	and manner as I place, and due	s stated. to the cause(s)	
	the the	Mec	29b. Signature and title of certifier	and manner state	ed.		290	. License r	number			29d Dat	e signed (Mont	h Nev Year)	
	, <u>3</u> E 8		Maria ~		O			1) 11	2000						
. '	541		20 November 4.	me h	+- /*·	00-1	Dalas'		18 04			Ton	mung!	6, 2004	
5	541		30. Name and address of person who co	mpleted cause of dea	in (Item	دعa) (Type, ا	Lace	L 124.		Lit	. 2/7	0			
	Sta	te	31. Date filed (Month, Day, Year)	366 Mg 32. Registrar 004	s Signati	TLO	renge	USTUL	W. ,	100	7 / (······································		
	Registr	Ar .	JAN 20 2	004		B. D.	carte	D							

			For State Registrar		State of N	/larylar		artmen <i>rtificat</i>				, ,	jiene	nnı	02671
	Physicia	an	Decedent's Name (First, Midd	fle, Last)	F. 1. 337	.t. D'						2. Date of Dea Month	th Day	Year	3. Time of Death 2: 39A. M
	/Medic				Ervin W		ttinger	41 01	-		(D-11)	Janu	ary 13,		
	Examin	er	4a. Facility Name (If not institution					4b. City,	I own, or	Location of			4c. Co	unty of Death	
				+	morial Hos		to a filt of a A	If Under	t 1 Voor	If Under	umbe				egany
	Funeral		5. Social Security Number 217-14-4304	6. Sex	M 2□F		last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day	, Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent			80	110.					August	07, 1923		Maryland
	and w		10a. State 10b. Count	y		10c. Ci	ity, Town or Lo	cation							10d. Inside City Limits
	dary f sho led a	ō	Maryland	Car	roll				1	Mount	A				1 ☐ Yes 2 🗷 No
	the t	ect	10e. Street and Number	Car				10f. Zic		Mount	Ally		10a. Citizen	of What Cou	ntrv?
	with	۵		0 A D	ennitt Cour	4				2177	. 1				
	eath	eral	11. Marital Status		2. Was Deceder		IS 13 V	Nas Dece	dent of His	2177		cifu Yes or No-	14.	Race - Amen	
98	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show dical Examiner must be notified at	y Funeral Director	1 Never Married 2 Ma	rried	Armed Force: 1 2 Yes 2 If Yes, Give	s? ∃No		f Yes, spe		Specify:	, Puerto	ecify Yes or No- Rican, etc.)		Black, White, ecify:	
ö	ural',	d by	3.X Widowed 4 □ Divorce		Year or Dates	S:									White
21215-0036	C * 3	Completed	15. Decede (Specify only high		completed)		16a. Deced (Give life.	lent's Usu. <i>kind</i> of wo DO NOT u	rk done d	uring mos	t of worki	ng	16b. Kind	of Business/Ir	ndustry
72	within iene. than "I	E	Elementary/Secondary (0-12)		College (1-4o	r 5+)			Cc	al Mir	er			Co	val
0	filed Hygid Sther ant, II		17. Father's Name (First, Middle	, Last)					- 1			(First, Middle,	Maiden Su		741
Maryland	should be filed id Mental Hygi marked other matic evant, I	To Be		Ja	acob Bitting	per						Tenn	ie Mae	Chrout	
₹	s 1 and 2 should b f Heatth and Ment item 27 is marked other traumetic e	1	19a. Informant's Name/Relation			501	19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	I Route Numbe			p Code)
Z	nd 2 salth ar 27 is 27 is r trau		Clark Lorraine			w						ourt, Moun			
Ġ	is 1 and of Health item 27 other to		20a. Method of Disposition		-gor reprie	20b. I	 Place of Dispo	sition (Nai	me of			ate		ion - City or T	
و	0 O		1 Ø Burial 2 ☐ Cremation		emoval from Stat	te	cemetery, crer	-	•		Ja	nuary 14,		CONTRACTOR OF THE PARTY OF THE	
Baltimore,	it. Partitude		* 4 □ Donation 5 □ Other (Mountai	IN VIEW				2004	Mos	cow Mill	s, Maryland
Ba	permit. Pag Department Important: I any injury o		2 5 Ma	Kom	t.		18		Eichh	ıorn-M	cKenz	ie Funeral			Main
			23a. Par1. Enter the disease, shock, or heart failure. Lis	or complications	cations that caus e cause on each	ed the dea	th. Do not ent	er the mod	de of dying	, such as	cardiac c	r respiratory ari	est, 2133	39	Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition		6	7	Tunen	ne	don		20	rter de	4400		Onset and Death
	/Medical		resulting in death)	r a	Due to (or a	as a conte	quence of):	-		4	- 000	un o	,	1	
	Examiner			b											
		je	Sequentially list conditions, it any, bading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	J	Due to (one	as a consec	quance of):							- 0	
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	1 .											
Ć.	be execute siclan and burial-trans		resulting in death) Last		Due to (or a	as a consec	quence of):								
8760	ate be	dlcal		d.											
68	ificate g phys as the	0 1		-									-		
Вох	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23	Bc. If yes, outcom			7					23d.	. Date of deliv	ery
m	death e atte d for	cia	in the past 12 months? 1 □ Yes 2 □ No		4☐ Pregnant	at time of]Ectopic p] Other <i>(sp</i>						Month	Day Year
P.0	at the de by the a	hys	9 Unknown		9□ Unknown										
υ, σ	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant condi-	ions con	tributing to death	but not res	sulting in the u	nderlying o	ause give	n in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?
rds	n sig											1□Y	es 2.DN	3 🗆 Prol	pably 4 □Unknown
Ö	w requ	ete										24a. Was a	ın 2	4b. Were auto	opsy findings available
Re	The lav	Completed										autop: perfor	med?	death?	mpletion of cause of
a	iician: Th certificate rector, pag	ပိ	OF Mean ages referred to modia	21						00.81	- (D 1)		2 No	1 🗆 Yes	2
of Vital Records,	iding Phyaician: th. After this certifica funeral director, i	00	25. Was case referred to medic examiner?	_	ospital:		3-60		Cthe			(Check only or		2011 10	. 1
oţ	Phy this ral di	2	1 ☐ Yes 2 ☐ No 27. Manner of Death		28a. Date of Ir		ER/Outpatier 28b. Time of		JA	4 LI NU	TANK TO SERVICE	me 5 Resid			(y)
ü	Jing After fune	ig Ig	1 ⊟Natural 5 □ Pend	ing tigation	(Month, L	Day Yeer)	Injury	м	28c. Injury Work 1 □ Y	? ′es 2.⊡l			,,		
Si	or Attanater death	ica	3 ☐ Suicide 6 ☐ Could	not be	28e. Place of	Injury - At h	nome, farm, str				_	28f. Location (S	treet and N	umber or Run	al Route Number,
Division	I or Attandi after death. Director: A I in by the fu	Certification;	4 ☐ Homicide deter	mined	building,	etc. (Speci	ify)	oot, ractor	y, omoo			City or Tow			
_	ppital ours ineral filled		29a. Certifier 1☐-Certify	ina Phys	ician: To the be	st of my kn	owledge deat	occurred	at the time	e. date an	d place. a	and due to the o	ause(s) and	d manner as s	tated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical			er: On the basis and manner	of examina									
	ompl	Me	29b. Signature and title of certif	er				1	c. License			1		igned (Month,	Day, Year)
1	1		· One	z a	Ulm ;	20			00	017	56	_	gen.	13, 20	30 4
- 1	IIVA		30. Name and address of perso	1			m 23a) /Tune	Print)	J =				/		
7	122		A J 361/in			2 JU &	-+1 A	- 6-7	6	2651	/e	71	21	504	
/	Sta	te	31. Date filed (Month, Day, Yea		32. Regis	strar's Sign	ature					<u> </u>	-		
	Registr		JAN 1 5 20	04	ha.	-01	19 1	par	12						

			ricase	State of Maryland / Depart				
			1 - State	-	artment of Health and rtificate of Death		2001, 0007	0
			Registrar 1. Decedent's Name (First, Middle, Last		rancate or Death	2. Date of Death	3. Time of Death	_
	Physici		Katherine Virgi			Month	Dey Yeer	4
	/Medi Examir		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of De		15 2004 /: 40 A * 4c. County of Death	_
			Clearview Nursin	g Home	Hagerstow	ın İ	Washington	
	Funeral		5. Social Security Number 6. Se	7.4	If Under 1 Year If Under 24 H Months Days Hours M	Irs. 8. Date of Birth in. (Month, Day, Y	9. Birthplace (State or Foreign	n
	Director		Usuel Residence of Decedent	M 2XX 86 Yrs.		Sept.19,	1917 West Virginia	_
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation	4	10d. Inside City Limits	
	Many Fed sh	ţō	Maryland Washi	naton	Boonsboro		1 ☐ Yes 為XXNo)
	th the	Director	10e. Street and Number		10f. Zip Code	10g	J. Citizen of Whal Country?	_
	be filed within 72 hours after death with the Maryland stal Hygiene. sd other than "natural", or Itams 23a or 28a-f show event, it a Medical Exacting in use the trialified at	ai	7830 Sharpsburg R	Pike	21713		USA	
	ar des	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, While, etc.	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 📉 No	1 ☐ Yes 2 ☒ No Specify:		Specify:	
9	72 hours after netural', or Ita dical Exaculne	edt	15. Decedent's Edu		dent's Usual Occupation	16	White b. Kind of Business/Industry	_
215	within 72 ene. then na	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) (Give	kind of work done during most of v DO NOT use retired)	vorking	o. Hard of Dasillossified sity	
21	giene giene er th	Com	12	50110g0 (1-40) 54)	Homemaker		Home	
nd	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last)		18. Mother's N	lame (First, Middle, Ma	iden Sumame)	
<u>ya</u>	should be and Menta marked umatic ev	ျ	Henry Cleveland	Gardner	Bert	ie Butler	Kave	
Mar	12 sho h and 7 is m		19a. Informant's Name/Relationship (Ty		ng Address (Street and Number or			
e,	nit. Pages 1 and 2 should artment of Health and Mer ortant: If Item 27 is marke injury or other traumatic 8.	1	Gardner Cook - Sor	20b. Place of Dispo	Sharpsburg Pike	Boonsboro,	Mary Land 21713 c. Location - City or Town, Slate	_
nor	Pages nent of int: If it		1XX Gurial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)	terrioval from State	osition (Name of matory or other place)	3		
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other otice.	l i	21. Signature of the ral Service Cons	/ Ledar Law	Vn Mem. Park Jan	.17,2004 Ha	gerstown Maryland	_
B	permit. Departrimports any inju		11/1/2011/16	0s	Name and Address of Facility Sborne Funeral Ho 25 S. Conococheac	ome,P.A.	:	
()			23a. Part1. Enter the disease, or compleshock or heart failure. List only or	ications that caused the death. Do not entine cause on each line.	er the mode of dying, such as card	ac or respiratory arrest	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Anterio Silva	To Caral Second		Onset and Death	
24	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	Lxammer	_	Sequentially list conditions	J	ultation		7	
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
<u>,</u>	e be executed /sician and e burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
760,	eath certificate be executed attending physician and for use as the burial-transit	call		1				
68	The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the	Medi	Te service					
Вох	th cer tendir r use	an/N	200. Was decedent pregnant	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐]Ectopic pregnancy		23d. Date of delivery	
П	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)		Month Day Year	
P.O.	res that the de signed by the a be detached f	by Physician/Medi		ntributing to death but not resulting in the ur	adashina sayas sayas is Dashi	02a Did tahun		
ds,	signe d be	d by	Mysertinia	Centra Varante			co use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\frac{\text{Hunknown}}{\text{No}} \)	
Vital Records,	w require been sig	Completed						_
Re	he lav e has ige 2	dmo	Carenzonia,	ugu bun		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?	
	an: T inficat or, pa		25. Was case referred to medical		OG Plans of D	1 Yes 2	No 1 ☐ Yes 2 ☐ No	
<u> </u>	Physician: The la r this certificate has ral director, page 2	o Be	examiner?	lospital:	0.1	eath (Check only one) Home 5 Residence	e 6 □Other (Specify)	
0	ding Ph h. After th funeral	T: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury		28d. Describe how i		
0	tendir seath. tor: Af the fu	atic	2 Accident investigation	(e., 2.5) 1.05.)	M 1 ☐ Yes 2 ☐ No			
Division of	f or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)	
	pital		20a Carifica AEI Cariffula Bhu			4		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examir	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place restigation, in my opinion, death occurred.	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)	
	ro the	Re	29b. Signature and title of certifier	and marries states.	29c. License number	29d.	Date signed (Month, Day, Year)	_
			-1324	~0	D18019		An 15 2003	
51	× \		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, F	,			_
5			VASANT DATT		LL ST MACE	RSTOWN	MD 21740	
	Sta Registra	te ar	31. Date filed (Month; Day, Year) 6 20	32. Registrar's Signature	and I			

	•		Pleas	e Type or						-		gible.		
			For State	State	of Maryla	•		f Health a of Death	ana mer		2	ONL	02	673
			Registrar 1. Decedent's Name (First, Middle,	Last)			imoato (or Dealir		Date of Death	J. No. 💪	. 0 0 4	3. Time of	Death
	Physici /Medic	al	Audrey Christens		umbae)		Ab City Town	m, or Location o	J	Month		2004 unty of Deeth	1532	М
	Examin	er	Union Hospital					1kton	n Death		40. 000	Cecil		
	Funeral			. Sex		. last birthday)	If Under 1 Y		24 Hrs. 8. Min,	Date of Birth	/oarl		lece (Stete o	or Foreign
	Director		219-34-5450 Usuel Residence of Decedent	1□M 2XF	71	Yrs.	Months	ays Hours	J1	Date of Birth (Month, Day,) une 28,	193	2 Mar	ÿland	
	death with the Maryland ims 23a or 28a-f show if toust be notified at		10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside C	•
	Ba-f s	Director	Maryland Ced	cil		E1kt				1				2 No
	with ti		10e. Street and Number 100 Laurel Drive				10f. Zip Cod	[∞] 1921				of What Coul	-	
	ms 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.		of Hispanic Orig Cuban, Mexican	gin? (Specify		14.	Race - Americ	an Indian,	
980	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Mudical Expriner mat be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Amed F d 1 Tes If Yes, G Year or I	2 X No ive		f Yes, specify (1 ☐ Yes 2 🖸			an, etc.)		^{Black,} White, _{ecify:} Whi		
Maryland 21215-0036	nin 72 ho In "naturi Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) (1-4or 5+)	16a. Dece (Give life.	dent's Usual Oo kind of work do DO NOT use re	ccupation one during most stired)	t of working	10	6b. Kind o	of Business/In	dustry	
21	ad within rgiene. er than	Com	12	2	(1-40: 07)	Di	shwash					aurant		
pui	be filed ital Hygi of other event, it	Be	17. Father's Name (First, Middle, La							irst, Middle, Ma				
<u> </u>	2 should be and Mental is marked a	T _o	James Brown McKe			10h Maili	m Address /Ct	Lei		rtha B			Cadal	
Mai	od 2 st lth and 27 ts r fraur		19a. Informant's Name/Relationship Kathleen French			1		dge Driv						
Baltimore,	s 1 and 2 of Health item 27 other tru		20a. Method of Disposition			Place of Dispo	sition (Name o	of (Date	20		on - City or To		
imo	T T e		1XXBurial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe			odlawn	•	J	anuary 2004		Balti	imore,	Mary 1	and
Salti	permit. Pages 1 a Department of Hes Important: If item any injury or othe		21. Signature of Fund Secure Li	ensag		22	. Name and A	ddress of Facility	y Crou	ch Fun	eral	Home		
	₹0 ± ₹ 0		Jahrer.	4				h Main S				st, Mar	yland Approximat	
	Physician		23a. Part 1. Enter the disease, or conshock, or heart failure. List or immediate Cause (Final disease or condition	a.	each line.	- n		dial by		_	it,		Interval Bet Onset and I	ween Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	-	,		1				Time! -	
		er	Sequentially list conditions, if any, leading to immediate	b	(or as a conse	rquence of):	,						unkz	101.027
	te be executed ysician and ie burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.	Alhe	rosclesi	otie to	Ceart I) islow	Le_		-	unka	2000
0,	be executed ician and burial-transif		resulting in death) Last	Due to	(or as a conse	quence of):								
8760,	ate be	dical		d										
89 x	Jeath certificate b rattending physic I for use as the b	/Med	IF FEMALE:	23c. If ves. or	utcome of preg	nancv					224	Date of delive	201	
.O. Box		Physician/Medi	23b. Was decedent pregnant in the past 12 manths? 1 □ Yes 2 □ No 9 □ Unknown	1 🗀 Live	birth 2 ☐ Fe nantat time of	tal death 3	Ectopic pregna Other (specif)				234.	Month		Year
a	requires that the d een signed by the hould be detached	by Phy	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	nderlying cause	e given in Part I.		23e. Did toba	cco use o	contribute to the	ne cause of d	leath?
rds	v require been sig should b	ed b	Mental K	elarda	Lien					1 ☐ Yes	2 🗆 N	o 3 Prob	ably 4 📑	Jnknown
of Vital Records,	e law has b	ompleted								24a. Was an autopsy performe		b. Were auto prior to co death? 1 \(\text{Yes}	npletion of c	available ause of
ita		Be C	25. Was case referred to medical examiner?		143.1			26. Place	of Death (C	heck only one)	2140	7	20110	
of V	d is	2	1☐Yes 2☑No			☐ER/Outpatier		Other: 4 Nu					1)	
	ding After fune	:lou:	27. Manner of Death 1 Natural 5 Pending		of Injury nth, Day Yeer)	28b. Time o Injury	- 3	Injury at Work? 1 ☐ Yes 2 ☐ N		. Describe how	injury oc	curred		
Division	Attender deatlector:	ertification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Plac	e of Injury - At ding, etc. (Spec	home, farm, str		_		Location (Stre City or Town,		ımber or Rura	l Route Num	ber,
	Hospitat or 24 hours afte Funeral Dir etely filled in	O	29a. Certifier 1 Certifying	Physician: To th	na bast of my kr	nowledge deat	occurred at th	ne time, date and	d place, and	due to the cau	se(s) and	manner as s	ated	
	ne Hos ne Fur stetely	edicai	(Check only 2 Medical Ex	caminer: On the	basis of examin	nation and/or in	vestigation, in r	ny opinion, deat	th occurred a	at the time, dat	e and place	ce, and due to	the cause(s)
	To the l within 2: To the I complet	W	29b. Signature and title of certifier	0 1 1		. 4		cense number	20-		-	gned (Month,		
)	acholin	5811	10	D	00233	322		Jan	mary	9,04	
	1		30. Name and address of person w	En Min	, 1181	Vorth &	7- Sui	t 3B	Elh	In Mi) 2,	1921	,	
	Sta Registi		31. Date filed (Month Day, Year)	Elseva.	Registrar's Sign	Agarle .	•							

			1 - For State Registrar	State of Mary	and / Dep		lealth and		_	02674
	Physici	an	1. Decedent's Name (First, Middle, Last)	Donald I	as Drie			2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give st	Donald L	lee Dye	4b. City. Town, o	r Location of Deat		4c. County of Dee	18:40 A.M
	Examir	ier	SACRED NEAR		HAL	A	DERlANG	1	ALLEG	
	Funeral Director		5. Social Security Number 6. Sex		yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) April 0:		thplace (State or Foreign buntry) Maryland
	and		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	the Maryl 28a-f sho	Director	Maryland Alle	egany		10f. Zip Code	Barton	100	. Citizen of What Co	1∰Yes 2 No
	3a or			n Railroad Stree	t	Ton Zip Godo	21521			USA
36	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dreal Examiner must be positied at	by Funeral	11. Marital Status 12 1 □ Never Married 2 □ Married 3 □ Widowed 4 🛣 Divorced	2. Was Decedent Ever Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ② No		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	encan Indian, e, etc.
9	72 hour	ted t	15. Decedent's Educa	ition	16a. Dece	dent's Usual Occup	ation	16	6b. Kind of Business	White Industry
Maryland 21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired				,
121	Hygien other th		17. Father's Name (First, Middle, Last)			Cons	truction Wo	rker ne (First, Middle, Ma		Labor
anc	ed la b	o Be	_	cob Lewis Dye			10. MOUTHER'S NAT		narity Broadw	atau
ary	S D E E	ပ	19a. Informant's Name/Relationship (Type	,		ng Address (Street	and Number or Ru	ral Route Number, (
	1 and 2 Health a am 27 is		James E. Dye-				ower George	es Creek Road	Moscow M	1, 21521
Baltimore,	S to L		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Re		-	matory or other place	·	Date 20 January 18,	c. Location - City or	Town, State
臣			4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licenses			berland Crem 2. Name and Addre		2004	Cumberla	nd,Maryland
Ba	permit. Departr Imports sny inj		23a. Parti. Enter the disease, or complici	7		Eic	hhorn-McKe	enzie Funeral		E. Main
	Pnysician /Medical Examiner	her	Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	M 222 sequence of):	The mode of dying the state of	, such as cardiac	or respiratory arr es		Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
.O. Box	The law requires that the death certificat the has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. If yes, outcome of property of Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	requires that been signed t should be det	by	Part II. Other significant conditions conti	ibuting to death but not	resulting in the u	inderlying cause giv	en in Part I.			the cause of death?
al Records,	(0	Completed						24a. Was an autopsy performa	d? prior to death?	itopsy findings available completion of cause of 2 No
Vital		o Be	25. Was case referred to medical examiner?	spital:	0.000	oth	ar.	th (Check only one)		
o	Attending Physic death. ector: After this by the funeral di	 	27. Manner of eath 1 Natural 5 Pending Accident investigation	1 A Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	f 28c. injun World	4 □ Nursing H	ome 5 Residence 28d. Describe how		cify)
Division	al or Atter s after dea Il Director d in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str ecify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying Physic	cian: To the best of my r: On the basis of exam- and manner stated.	knowledge, deat nination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifler	1//1		29c. Licensi	e number	290	. Date signed (Month	h, Day, Year)
	1		1 7/	Mym.	2	D	1541	3 Ja	mairy (3,2004
	TILS		30. Name and address of person who com	pleted cause of death	Shook	Print)	mere and	SEL Y.	N 4	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	1 WES	11 care	M; 110	D 8/21	02
	Registr		JAN 1 5 2004	he sense	19	bould				

			1 - For State Registrar	State of Man		artmen rtificate				F	leg. No.		02	675
	Physici /Medio	al	Decedent's Name (First, Middle, Last VINETA 4a. Fecility Name (If not institution, give	DY	E	4b. City.	Town, or	Location of		2. Date of Dea Month January	Day 12,	Year 2004 County of Deat	3. Time o	
	Examir Funeral	er	3848 Salem Churc 5. Social Security Number 6. S	ch Road	n yrs. last birthday)	1	rret	svil If Under 2 Hours	1e Nin.	B. Date of Birtl	H Year)	larford 9. Birt	hplace (State untry)	or Foreign
	Director wods	J.	Usual Residence of Decedent 10a. State 10b. County	10	94 Yrs. Dc. City, Town or Lo				[1	March 2	25, 1	1919 0	hio 10d. Inside (
	h with the M 23s or 28s-f at be nutifie	al Director	Maryland Washir 10e. Street and Number 850 Frederick St		па	gersto 10f. Zip		740			10g. Citiz	ten of What Co		
980	d within 72 hours after death with the Maryland litene. r than "natural", or Items 23a or 28a-f show tha Medical Ezaninar must be mulfied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S. 13.	Was Deced If Yes, spec		spanic Orig , Mexican, Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		4. Race - Ame Black, White Specify:		
Maryland 21215-0036	within ane. than "	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)		(Give	dent's Usua kind of wor DO NOT us	k done d e retired)	uring most	of working	9		ical	Industry	-
yland 2	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) Samuel Tyrunes F	Robison					Del1	First, Middle,	man			
	1 and 2 Health a		19a. Informant's Name/Relationship (Lillie C. Augenst 20a. Method of Disposition	ein - siste		8 Sale	em Ch	urch		Jarre	ttsv	Town, State, 2 ille, Mo cation - City or	1.21084	•
Baltimore,	permit. Pages Department of I Important: If it any injury or o'		1 Surial 2 Cremation 3 4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer	y)	Rest Hav	ven. Ce 2. Name and	emete d Address	ry]	MI	NNICH	FUNE:	rstown, RAL HOM n, Md.	Œ	and
}	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only tmmediate Cause (Final disease or condition	plications that caused the one cause on each line.		-	e of dying	, such as o				II, FIG.	Approxima Intervat Be Onset and	tween
8760,	/Medical Examiner hysician and the prival-transit	lical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	ASTATIONS EQUENCE OF):	ME	TELA	-ANO	nA nA				6 M	WHS
P.O. Box 68	death certific e attending p ad for use as	Physiclan/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetel death 3	⊒Ectopic pre ⊒ Other (spe					2:	3d. Date of deli Month	very Day	Year
Records, P.	en sign	by	Part II. Other significant conditions o	ontributing to death but n	oot resulting in the u	inderlying ca	ause give	n in Part I.		23e. Did to	1	se contribute to	the cause of	
al Rec	The ate h page	e Completed	25. Was case referred to medical					00.51			mad2 2 4 No	24b. Were au prior to death? 1 🗌 Yes	topsy findings completion of	available cause of
Division of Vital	ding Phys	ation; To B	examiner? 1 Yes 2 Lino 27. Mannar of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpaties 28b. Time of Injury		8c. Injury Work	r: 4 🗆 Nur	rsing Home	Check only or e 5 ☐ Resid d. Describe h	ence 6	Other (Spec	HOME FAMIL ME	MBER
Divis	S = E	l Certifica	3 Suicide 6 Could not be determined	building, etc. (S	Specify)				28	City or Tow	n, State)	Number or Ru		nber,
	To the Hospital of within 24 hours all To the Funeral D completely filled in	Medical	(Check only one) 2 Medical Examone) 29b. Signature and title of certifier	ysician: To the best of miner: On the basis of example and manner stated	amination and/or in	ivestigation,	in my op	nion, death	h occurred	at the time. d	ate and p	place, and due signed (Month	to the cause(s)
	7° ≥ 1° 0° 0° 0° 0° 0° 0° 0° 0° 0° 0° 0° 0° 0°		30. Name and address of person who	completed course of death	h (ltem 22a) (Tues		Λ	2 77	30		1	601 13	2 00	4
17	\$		31 Date filed (Month Day Year)	32 Booistrar's	9 N. C	ypau	EJ J	T. 1.	5447	740K	£, 4	P 21	204	
	Sta Registi		JAN 15 2	2004 Agreen	B. A	outed								

			1 - For State Registrar		ryland / Dep		Health and		-	02676
	Physici /Medic		1. Decedent's Name (First, Middle, Las Robert Willian	•				2. Date of Death Month	Day # Year	3. Time of Death 4 12:51cm
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Deat		4c. County of Dea	ith
			Washington Co				gerstown		Washing	ton
ļ	Funeral Director		5. Social Security Number 6. S 217-16-2792 Usual Residence of Decedent	7. Age	(In yrs. last birthday,	If Under 1 Year Months Days		Month, Day, Y		thplace (State or Foreign ountry) laryland
	ahow	_	10a. State 10b. County		10c. City, Town or L		** C + O T ***			10d. Inside City Limits
	28a-f	recto	Md. Washin	igton		10f. Zip Code	rstown	100	. Citizen of What C	1 Yes 2 No
	th with 23a or	ai Di	207 Jackson Ave			101. 210 0000	21740	100	U.S.A.	ound y ?
5-0036	2 should be filed within 72 hours after death with the Maryland and Mentat Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinat must be unfilled at	by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Endemed Forces? 1) I	Was Decedent of in the state of the state o	Hispanic Drigin? (S pan, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
21215-0	vithin 72 ho ne. han "natur s Wedical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+	(Give	DO NOT use retire	during most of wor	king	b. Kind of Business	,
	filed v Hygien other th		17. Father's Name (First, Middle, Last)	4		Engin			Industry	
Maryland	should be find Mental H marked of umatic ever	To Be	Unknown					ne <i>(First, Middl</i> e, Ma Unknown	iden Sumame)	
	rtr Tr		19a. Informant's Name/Relationship (7 Lucille B. Davis		19b. Maili 207	ng Address <i>(Str</i> eet Jackson	and Number or Ru Ave. Hage	ral Route Number, C erstown , Md	city or Town, State, . 21740	Zip Code)
altimore,	Pages 1 an nent of Heai int: If item 2 iry or other	13	20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐	Removal from State	20b. Place of Dispo cometery, cre-				c. Location - City or	Town, State
altim	permit. Pages Department of Important: If it any injury or o		4 Donation 5 ☐ Other (Specify) 27. Signature of uneral 3—wee Literature			rg Crema Name and Addre		2004	Smithsbur	
Ö	F F F S	1 10	Jennis Z.	rain		vis Fune		Smithsb	radbury A urg,Md. 2	ive. 1783
	Pnysician /Medical		23a. art1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Acuk	Rena	er the mode of dyil	ng, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
188	Examiner		Sequentially list conditions, if any, leading to immediate	b. Due (or as a	consequence of):	Shoen	_			
	cuted od ransit	Examiner	rany, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Clario	consequence of):	ale	infect	· .		
8760,	ate be executed hysician and the burial-transit	ical	resulting in death) Last	d. Due to (or as a	consequence of):	a.				
O. Box 6	at the death certifica by the attending phatached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy	у		23d. Date of del Month	ivery Day Year
rds, P			Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac		the cause of death?
Hecords,	The law te has b	Completed						24a. Was an autopsy performed	d? prior to death?	stopsy findings available completion of cause of
Vita	cian: ertific ector.	Be	25. Was case referred to medical examiner?					th (Check only one)		
		7	1 ☐ Yes 2 Ø No 27. Manner of Death	Hospital: 1 Inpatient			4 Li Nursing H	ome 5 Residenc		cify)
0	ge e	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)	(ear) 28b. Time of Injury	Wor	yat k? Yes 2 □No	28d. Describe how	injury occurred	
Division of	al or Attending Phy s after death. I Director: After thi d in by the funeral o	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)			28f. Location (Stree City or Town, S	t and Number or Ru tate)	iral Route Number,
	To the Hospital or a within 24 hours after To the Funeral Direct completely filted in E	ledical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	n occurred at the tir restigation, in my o	me, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
		Σ	29b. Signature and title of certifier	9		29c. Licens	(a) 2 2 8	29d.	Date, signed (Mont/	n, Day, Year)
,	ik it		30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Type,	Print)	مدار	hala	21/3	
	Sta	- 01	31. Date filed (Month, Day, Year)	32 Registrar	14 March	its	1349.	ma 21	170	
9.3	Registra	ar	JAN & U ZU	A 16 1613-	1					

		For S 1 - Stete Registrar	tate of Marylan		artment of Hea tificate of De			iene 200	4 02677			
		Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Yee	3. Time of Death			
Physicia /Medic		Willia	m Earl Dagg				FANNARY	ry 17 2004 2:45 A				
Examin		4a. Facility Name (If not institution, give street	1 /		4b. City, Town, or Loc	eation of Death	1	4c. County of D				
		VA MARYLAND Health (5. Social Security Number 6. Sex	ARC SUSTER		If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	CECI	Birthplace (State or Foreign			
Funeral Director		217-26-7420 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Yrs.		lours Min.	(Month, Day, June 28	, 1930	Birthplace (State or Foreign Country) Maryland			
		Usual Residence of Decedent		, Town or Lo				<u></u>				
arylan show		10a. State 10b. County		10d. Inside City Limits 1 ☐ Yes 2X No								
Ba-f	ecto	Maryland Cecil		Port De	posit		10g. Citizen of What Country?					
with ti	吉	10e. Street and Number 232 Craigtown Road			10f. Zip Code	904		S.A.				
be filed within 72 hours after death with the Marylan tall Hygiene. And other than *natural*, or Itams 23a or 28a-f show event, the Marical Examiner must be natified at	Funeral Director	11 Marital Status 12.	Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hispa f Yes, specify Cuban, M		cify Yes or No-		merican Indian,			
or Itan		1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	1			Rican, etc.)		ck, White, etc.			
ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1951	-52	I□Yes 2⊠No S	pecify:		Specify:	White			
72 h	Completed	15. Decedent's Educati (Specify only highest grade co	16a. Deced (Give	lent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of workir	ng T	V.A. Medical Center					
within ane than	d L	Elementary/Secondary (0-12) Eight Years			int, Maryland							
fited v Hygie thar i		17. Father's Name (First, Middle, Last)		Cai	rpenter/Pai			faiden Sumame)	,,			
ld be ental kad o	To Be	Everett	ner Gladys DuBree									
and years Z. E. E. C. C. C. C. C. C. C. C. C. C. C. C. C.	-	19a. Informant's Name/Relationship (Type,	Number or Rura	Route Number,	City or Town, State	or Town, State, Zip Code)						
and 2 ealth a m 27 is		Barbara A. Dagg (wi	fe)	232 (Craigtown R	load, Po	rt Depos	sit, Mary	land 21904			
of He		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Rem	^	lace of Dispo- emetery, cren	sition (Name of natory or other place)			20c. Location - City	or Town, State			
Pages ment of t ant: If its ury or o		`4 □Donation 5 □ Other (Specify)	R.	A. Ferri	is & Co., Inc.	. 01/19	9/04 h	lest Chester	, Pennsylvania			
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnes.		21. Signature of Funeral Service Licensee	al soon	Le	Name and Address of e A. Patte erryville,	rson & S	Son Fune 1 21903	ral Home.	, P.A.			
		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one complicate shock.	ons that caused the death						Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition		Onset and Death								
/Medical Examiner		resulting in death)	ENT									
LAdimilei	er	Sequentially list conditions, b										
ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
execu n and ial-tra	Examin	that initiated events c										
ate be executed only sician and the burial-transit	dicall	d		_								
tificat ng phy as th	(i)	IE EE MALE.										
w requires that the death certifical requires that the death certifical been signed by the attending phenould be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23d. Date of Month	delivery Day Year							
the all	/slcl	1 Yes 2 No			-1. ,							
that the ad by detac		Part II. Other significent conditions contrib	23e. Did tob	b. Did tobacco use contribute to the cause of death?								
signe d be	d by	•	1 🗆 Ye	1 Yes 2 No 3 Probably 4 2 Unknown								
w requ	lete		24a. Was a	24a. Was an 24b. Were autopsy findings available								
he lay e has	Completed		autopsy prior to completion of cause of death?									
sician: The law scertificate has b lirector, page 2 sl	a	25. Was case referred to medical	(Check only on	12.100 12.10								
ysicii is cer direc	To B	examiner? 1 ☐ Yes 2 No	ne 5 Residence 6 Other (Specify)									
ding Phys		27. Manner of Death 1 S€Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)		8d. Describe ho							
eath.	catle	2 Accident investigation	28e. Place of Injury - At ho	2 🗆 No								
or Att fler d Siract in by I	Certification:	3 Suicide 6 Could not be 4 Homicide determined	Street and Number or Rural Route Number, wn, State)									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funarial Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit												
na Hos n 24 h na Fur netely	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To the within To the comp	ž	29b. Signature and title of certifier		29c. License nu			od. Date signed (Mo					
		· MI			D 5.	D 52739 Jan 17, 2004 AND Health Care System Parry Poin						
5+1VA		30. Name and address of person who comp	leted cause of death (Item	23a) (Type,	Print)	100/11	0 <	1. 1.	Land -			
Sta	to.	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	HRYLANO 1	104/74	CARC J	gsicus Ph	rig to in!			
Registr		JAN 2 0 2004 &	Column H.	docule	,		,		67			

Amended #19b, nls, 01/14/04, Allegany Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Tor State of Maryland Registrar 1. Decedent's Name (First, Middle, Last)	/ Department of Health and M Certificate of Death	ental Hygiene Reg. No. 2004 026 2. Date of Death 3, Time of Deat													
Physicia /Medic Examin	ai	ODESSA MAY FAZENBAKER 4a. Facility Name (If not institution, give street and number) CUMBERLAND NURSING CENTER	4b. City, Town, or Location of Death	JANUARY 11, 2004 11:30 P 4c. County of Death ALLEGANY													
Funeral Director		5. Social Security Number 218-24-8121 Usual Residence of Decedent 6. Sex 1 □ M 2 M F 7. Age (In yrs. lat.	Yrs Months Days Hours Min.	8. Date of Birth (Month, Day, Year) MAY 7,1912 9. Birthplace (State or Fore Country) WEST VIRGINI													
e Marylan Ba-f show diffed at	Director	MD ALLEGANY CR	Town or Location	10d. Inside City Lin 1 ☐ Yes 2 🌠													
23a or 2	al Dire	10e. Street and Number 12914 SIXTH AVENUE	10f. Zip Code 21502	10g. Citizen of What Country? U.S.A.													
	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto for 1 ☐ Yes ②【 No Specify:	cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE													
be lied within /z hours ttal Hygiene. d other then "natural", event, the Munical Ext	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16b. Kind of Business/Industry ALLEGANY COUNTY BOAR OF EDUCATION														
	To Be (17. Father's Name (First, Middle, Last) JAMES FARRIS	18. Mother's Name NETTIE	(First, Middle, Maiden Surname) SWANGER													
of Health and If itam 27 Is m or other traum		Minuse of Commission of Themposition Chair	netery, crematory or other place)	Route Number, City or Town, State, Zip Code) eSa Ptown MBERI-AND, MD 21502 ate 20c. Location - City or Town, State /2004 CUMBERLAND, MD													
Department Important: any injury o		21. Signature of Funeral Service Licens-le	22. Name and Address of Facility UPCHURCH FUNERAL HO	ME, P.A.													
nysicia he bur	Immediate Cause (Final disease or condition resulting in death) Acute Conjestive Heart Failure Due to (or as a consequence of): Coronary Artery Disease Bank, leading to inimediate of the conjective of the c																
by the attending phitached for use as the	ysiclan/Me	ysiclan/Mec	ysiclan/Med	ysiclan/Me	ysiclan/Me	nysiclan/Me	nysiclan/Me	hysiclan/Me	ysiclan/Me	nysiclan/Me	nysiclan/Me	Physiclan/Med	hysiclan/Me	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 ☐Ectopic pregnancy	23d. Date of delivery Month Day Year
igne be d	þ	Part II. Other significant conditions contributing to death but not resulting Metabolic Encephalopathy	23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkn														
	Completed	Pneumonia and Chronic Hypoxemi	24a. Was an autopsy performed 24b. Were autopsy findings avails prior to completion of cause death? 1 Yes 2 No														
s in in	atlon; To Be		26. Place of Death (Check only one) Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Time of Injury Mork? M 1 Yes 2 No														
rs after death al Director: ed in by the	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	288. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)														
n 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)															
Stat Registra		30. Name and address of person who completed cause of death (Item 2 S, L. Sanhir, M.D. – 48 31. Date filed (Month, Day, Year) JAN 14 2004 32. Begistrar's Signatur	3a) (Type Print) Terrace, Fr	1.2/200													

	, JHI	•	1 _ For	Stat			d / Depa		t of H	ealth a	and M	lental Hy	giene	200	L	02670	
			Registrar 1. Decedent's Name (First, Middle	a last)				umout	0/ 1	Joann		2. Date of De	Reg. No.	_ 0 0	-6	3. Time of Death	_
	Physici	an	MARIE	В.		EI	RANCIS					Month	Day			07:40 A M	
130	/Medic	al	4a. Facility Name (If not institution		of sumbos)	FI	MICIS	4h City	Town or	Location of	of Death	JAN.		2004 County of D		07:40 A	_
	Examin	er									or Death		40.	CECIL			
			SUNBRIDGE NUR 5. Social Security Number	6. Sex		e (In vrs I	ast birthday)	If Under	LKTO 1 Year	If Under	24 Hrs.	8. Date of Bi	rth			ace (State or Foreign	_
	Funeral		221-22-7917	1 □ M 2 €	SF 7.A9	83	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Do OCT • 7	ay, Year) 1 Q 2 (Count	RYLAND	
	Director		Usual Residence of Decedent									7	91720			INT DAND	-
	/land		10a. State 10b. County			10c. City	, Town or Lo	ocation			•				10	d. Inside City Limits	
	Many fied	ţō	MD CECI	ī.			ELKTO	N								1 X Yes 2 ☐ No	
	1 the	rec	10e. Street and Number			·		10f. Zip	Code				10g. Citiz	zen of What	Count	ry?	_
	3a o	0	1 PRICE DR.					2	1921				US	SA			
	ter death with the Marylan Items 23a or 28a-f show Incr must be nutified at	Funeral Director	11. Marital Status	12. Was	Decedent ed Forces?	Ever in U.:	S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	o- T	14. Race - A			_
9	after or ite	Ē	1 ☐ Never Married 2 ☐ Mar	ied 1 🗌	Yes 2 📉			ii ies, spec 1∐ Yes 2				nican, etc.)		Black, W			
සි	rail', o	þ	3 Nidowed 4 Divorced		r or Dates:			10 165 2	Z	эрвспу.				Specify:	WII	ITE	
5-0	d within 72 hours after death with the Maryland Jene. r than "natural", or items 23a or 28a-f show the Medical Evantres must be nuitified at	Completed	15. Deceden (Specify only highe	t's Education	eted)		(Give	dent's Usua kind of wor	k done d	turing mos	t of worki	ng	16b. Kii	nd of Busine	ss/Indi	ustry	
2	ithin	du	Elementary/Secondary (0-12)	Ť	ege (1-4or	5+)	life.	DO NOT us	e retired)			RET	AIL M	USI	C SALES	
7	7 7 -		8th	1		l	BOOL	KKEEPI	EK								_
밀	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle,									(First, Middle		Sumame)			
χ	ould be Menta Marked Marked	ဥ	STEPHEN M. PO							ANN	4.3	IWANIE					
Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other traumatic event,	11 1	19a. Informant's Name/Relations					-				i Route Numb	-			Code)	
6	s 1 and 3 f Health item 27 other tr		DIANE F. KEEN -	- DAUGH	TER	20h PI	2021 ace of Dispo			DR.,		MINGTOI Date		198 cation - City		un State	_
5	Pages 1 nent of H int: If ite	1 3	20a. Method of Disposition 1 Burial 2 ☐ Cremation		from State	Cé	emetery, crei	matory or o	ther plac	· .							
Baltimore,	permit. Pages Department of Important: If i any injury or once.		`4 □Donation 5 □Other	-		GRA	CELAWN					14,'04		CAST		DE.	_
3al	permit Depar Impor any in		21. Signature of Fundal Soulce	Cicer see	/) 2	PICER	e-Mui	LLIKI	N FU	NERAL I	HOMES	, INC			
_	0 0 ≥ € 0		21. Signature of Fundal Mice Cooksee Spirite and Address of Facility FUNERAL HOMES, INC. 1000 N. DUPONT PKWY., NEW CASTLE, DE 19720														
			28a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death														
и	Physician	X 4	Immediate Gause (Final disease or condition Chronic Obstanctive Vulmour Disceuse Tinkingum														
	/Medical Examiner		resulting in death) Due to (or as a consequence of):														
	Examiner		Sequentially list conditions.	b											1		_
	D iii		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.														
	and trans	Exam	that initiated events c,											_			
760,	be executed sician and burial-transit	0	resulting in death) Last Due to (or as a consequence of):														
87(± ≥ ±	dical		d										-	-		
x 68	The law requires that the death certificat ate has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE:	- 22- 16		-4									1	-	_
Вох	ath o	ian/	23b. Was decedent pregnant in the past 12 months? State								2	23d. Date of delivery Month Day Year					
<u>.</u>	the a	slc	1 ☐ Yes 2 💯 No 9 ☐ Unknown		Pregnant a Unknown	t time of de	eath 5	∃ Other (sp	өслу)								
P.O.	that the de sed by the a detached f	Ph		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e Did	tohacco u	co use contribute to the cause of death?			-
s,	res ti signe	þ	Dialo	Λ .	liters	, at 110t 100d	and a second	indonying o	addo give	on mir and	•					biy 4 🗆 Unknown	
Ö	w requir been si should	Completed	10	^						-				1			
ec	law lasb	pldu	Organic Brain Syndrewe									24a. Was	psy	prior	to com	sy findings available pletion of cause of	
=		ပ်	•									1 ☐ Yes	2 No	death 1 □ Y		!□ No	
Vital Records,	sician: Th certificate irector, pag	Be	examiner?									ath (Check only one)					
of \	Physician: rthis certificanal director,	၉	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🛣 Nursing Hor									ome 5 ☐ Residence 6 ☐ Other (Specify)					
L	ding P h. After t funera	5	27. Manner of Death 28a. Date of Injury 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1									28d. Describe how injury occurred					
sio	Attending or death. ector: After by the fune	catl	2 Accident investigation M 1 Yes 2 No								-	2011	-				
Division	or Attence efter death Director: In by the	Certification;	4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	e Hospital or At 24 hours efter of e Funeral Direc letely filled in by																_
	Hospital 24 hours e Funeral I tely filled	edical	(Check only 2 Medical	ng Physicien: Examiner: On	the basis of	f examinat											
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	Med	29b. Signature and title of certifie		i manner st	તાસવી.	· · · · · · · · · · · · · · · · · · ·	290	. License	number			29d. Date	signed (Me	onth. D	av. Year)	_
	5 ½ 5 0	-		elider	C	111			-	2332	2			14.04		-,/	
														17,00	T ·		_
	2		30. Name and address of person	who completes	cause of	death (Item	23a) (Type.	Print)	R	FOL	7.	MD21	901				
	1		31. Date filed (Month, Day, Year,	IND,	32. Registi	rar's Signa		ne o),	LER	en.	1102	1				_
	Sta Registi		JAN 1 6 2004		oz. negisti	M	Some !!	,									
	5.00		TO TOO.	100	ALCOHOL:	~ /	A PROPERTY										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) ^{Day} 17,2004 **Physician** January Anna Belle Friedberg 7:26 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ospital Clinton

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 20,1928 Southern Maryland Hospital Prince George 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☑ F Maryland Director 217-42-4111 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28e-f ehov the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Charles Indian Head 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7060 Riverside Rd. 20640 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F is marked of 0. Louis Wheeler Alice C. Speake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health a 8530 Riverside Rd., Nanjemoy, Md. 20662 David Friedberg Son 20b. Place of Disposition (Name of cometery, crematory or other place) Jan. 21, 2004 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) ō Chicamuxen United Methodist Chicamuxen, Marylan 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Williams Funeral Home, P.A. 20640 Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00668 4270 Hawthorne Rd., Indian Head, Approximate Interval Between Onset and Death Arctioschentic hourt Disoure Immediate Cause (Final disease or condition resulting in death) **Physician** 30 Minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Insulin Deportont Dishake Mellihus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 45 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 📉 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Xinpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel c within 24 hours af To the Funerel D Medical 29a. Certifier 15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies-29c. License number 29d. Date signed (Month, Day, Year) Willia I Jame un D35206 JAMMY 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Tannel FI Washington Med. 11701 Livingston #101 31. Date filed (Month, Pay, Year) 32. Registrar's Signature State JAN 2 0 2004 Mesur Registrar

			1 - For State Registrar	State of Maryland / Depa	irtment of Health and tificate of Death	Mental Hygie	
7	Physici	an	Decedent's Name (First, Middle, Last, Raymond Da	niel Fetzer		2. Date of Death Month	Day Yeer 3. Time of Death
,	/Medic Examin	al	4a. Fecility Neme (If not institution, give		4b. City, Town, or Location of Dea	JANVa	4c. County of Deeth
3.50	Examin	er	Southern Maryla		Clinton		Prince George's
4	Funeral		5. Social Security Number 6. Sec	TM 2005	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Yo	
3.	Director		203 16 3402 X	77 Yrs.		April 6	, 1926 PA
	show	<u></u>	10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	Maryland Prince G	eorge Clint	ON 10f. Zip Code	100	Citizen of What Country?
	h with			hwood Place	20735		United States
9	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Experiment mate by notified at	Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married	Armed Forces? If	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer ☐ Yes▼▼☐ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
9	hours tural',	ed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates: 1944-1946	ent's Usual Occupation	100	Specify: White
21215-003	filed within 72 Hygiene. ther then "nei the Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) (Give i	ent's Osual Occupation kind of work done during most of wo PO NOT use retired)	rking	b. Kind of Business/Industry
	filed withi Hygiene. other than	Com	12		Employed		Construction
Maryland	ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Leroy Fetzer			me (First, Middle, Mai	
چ	s 1 and 2 should be f Health and Mental Item 27 is marked o other traumatic eve	70	19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Mailin	Mary g Address (Street and Number or R	Gillesp ural Route Number, C	
	od 2 lith a 27 is r tra		Fonda Fetzer (Wi	fe) 7117	Branchwood Plac	e, Clinton	, Maryland 20735
altimore,	Pages 1 aunent of Heanint: If Item		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ P	20b. Place of Dispos cemetery, crem	atory or other place)		c. Location - City or Town, State
E			* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Lee Crema			inton, Maryland
Ba	permit. Departr Importa any inji		Most Odla	M M00153 A1	exandria Ferry R	oad, Clint	
	Dhusisian		shock, or heart failure. List only or Immediate Cause (Final	ications that caused the death. Do not entered cause on each line.	trutive Puli		Interval Between
•	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	rayine in	more sy	15 Cas C
	Examiner		Sequentially list conditions,	o			
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dualto (or as a consequence of):			
oʻ	execu in and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a consequence of):			
8760	cate be executed physician and the burial-transit	dical		d.			
9		a	IF FEMALE:	3c. If yes, outcome of pregnancy		7	23d. Date of delivery
O. Box	at the death certifi by the attending tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live birth 2☐Fetal death 3☐	Ectopic pregnancy Other (specify)		Month Day Year
ດົ	res that igned b be deta	by Pt	Part II. Other significant conditions cor	ntributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ord	w require been sig should b					1 🗆 Yes	2 No 3 Probably 4 → Hiknown
I Kecords,	e las has	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? To 1 Yes 2 No
VITa	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	Othor	ath (Check only one)	
ō	Phys r this ral di	2:1	Y Yes 2 No 27. Man or of Death	28a. Date of Injury 28b. Time of	28c. Injury at	lome 5 Residence	e 6 ☐Other (Specify) njury occurred
0	Attending In death.	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
DIVISION	et or Attens s after deat il Director: id in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospitel or Al within 24 hours after or To the Funeral Directompletely filled in by	Medical (29a. Certifier 1 Certifying Physical Check only 2 Medical Exemition	sicien: To the best of my knowledge, death ner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place estigation, in my opinion, death occurred	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the compte	ž	29b. Signature and title of certifier	11 -	29c. License number	29d.	Date signed (Month, Day, Year)
)			Holorda 1	glaster 20	HU=33921	Jr	wary 13, 2003
ì	R HALA		30. Name and address of person who co	impleted cause of death (Item 23a) (Type, F	Print) Drive (ho =	1 May	Land
Ė	Sta	te	31. Date filed (Month, Day, Year)	32. Fegistrar's Signature	for Ma	10	3
	Registr	ar	DAILETT	THE PROPERTY AS	M. C.		

			\$	State of Man	,	epartme C <i>ertifica</i>				giene _{Reg. No.} 2 N	ni.	12600
	_		Decedent's Name (First, Middle, Last)						2. Date of De	ath		Time of Death
	Physicia		Victor Hill Gebhar	•+					Month	Dey 2	Year 004	C.1E DM
	/Medic	al -	4a Fecility Neme (If not institution, give str		ulia Ma	nor		b. City, Town, or L	Januar ocation of Deat			6:15 PM
1	Examin	er	333 Mill Street	, 0	ulla Pic	ILIOT	:	Hagersto	าเพา	Wash	ington	County
-	Current		5. Social Security Number 6. Sex	7. Age (/	n yrs. last birth		der 1 Year	If Under 24 Hrs.		th V	9. Birthplace	Stete or Foreign
	Funeral Director		234-38-1558 ^{1A}	/ 2□ F	77 Yr	Month	ns Deys	Hours Min.	NOV.	7, 1926	Wheeli	ng, WV
		-	Usuel Residence of Decedent									
	yland		10a. State 10b. County	10	c. City, Town	or Location						side City Limits
	Mar Mar	후	Maryland Washingto	on	Casca	ade					1	☐Yes ŽŪNo
	# 22 a	Director	10e. Street and Number			10f.	Zip Code			10g. Citizen of V	What Country?	
	Sa Sa	[5821 Rowland Hill R	≀oad			21719	-1939		U.	S.A.	
	deat	Funeral	11. Marital Status	. Was Decedent Eve	r in U,S.	1		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		e - American Inc	dian,
Baltimore, Maryland 21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or fterns 23s or 28s-f show ent, tre Medical Examinat rount be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:			pecily Cuba 2 No		nican, etc.)		ck, White, etc. :: White	
ŏ	2 ho	Completed	15. Decedent's Educa	tion	16e. D	ecedent's U	sual Occup	ation	ina	16b. Kind of Bu	usiness/Industry	,
215	Z ulc	를 -	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	"	Give kind of ife. DO NO	work done of use retired	during most of work d)	ang			
21	iene. Than	E	Elementary/Secondary (0-12)	4	I	Archit	echt			College	e	
D	be filed withir ital Hygiene. d other then event, tre M	Bec	17. Father's Neme (First, Middle, Last)	•	'			18. Mother's Nam	e (First, Middle			
lan	2 should be filed and Mental Hygi is marked other aumatic event, it	10 B	Victor Hugh Gebhart					Ther	esa Coo	k		
Σ	d 2 should th and Mer T is marke traumatic	-	19a. Informant's Name/Relationship (Type	o, Print)	19b. N	Mailing Addr	ess (Street	and Number or Ru			State, Zip Code	⁹ 1939
Ž	TELS		Patricia Pile Gebha	rt/Wife	58	321 Ro	wland	Hill Roa	d, Casc	ade, Mai	ryland :	21719-
ō,	- 7 5 5	t	20a. Method of Disposition		20b. Place of D	Disposition (/	Vame of	201	Date	20c. Location -	City or Town, S	itate
ē	0 0 <u> </u>		1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Rest H	crematory of		ery J	an,12,0	4 Hagers	stown, I	Maryland
=======================================		-	21. Signature of Funeral Service Licensee					ss of Facility Do		_		
Ba	permit. Departr imports any inju		Million of	N TIME	up	1331	Easte	rn Blvd.	N. Hage	rstown,	Maryla	nd
	- FW - FW -	1	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the cause on each line.	death. Do no	t enter the n	node of dyin	g, such as cardiac	or respiratory a	rrest,	Appr	roximate val Between et and Death
)	Physician		Innerediate Ones /Final			2					1	
	/Medical Examiner	1	Immediate Cause (Finel disease or condition resulting in death)	METST	ATIC	130	NE	CANO	FR		12	M
			resulting in deality		e to (or as a co							
	Sit 9d	틸	b								1	
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions,	Du	e to (or as a co	nsequence	of):					
30,	Se ex		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury									
68760,	hysik the t	edicai	that initiated events resulting in death) Last	Due	e to (or as e co	nsequence o	of):					
-	ing p	Š	d									
Вох	eath certifi attending d for use as	an	0.1									
	it the dea by the at itached fo	3	Part II. Other significent conditions contri	buting to death but n	ot resulting in t	he underlyin	g cause giv	en in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death?
P.0	at the	Physician/M							10	Yes 2□ No	3 Probably	4 Unknown
Ś	es that igned b	ক্র						-				
בַ	v require been si should I	Completed							24a. Was	en autopsy rmed?	available	utopsy findings e prior to
ပ္ထ	aw re Is be	pie									of death	ion of cause ?
Œ	The law ate has page 2	E							10	Yes 2 No	1 □ Yes	2□ No
of Vital Records,		Be	25. Was case referred to medical					26. Plece of Deat	th (Check only o	one)	L	
>	Physician: rthis certific ral director,	2	examiner? 1 ☐ Yes 2 🕱 No	spital:	2 ER/Outp	atient 3	DOA Oth	er: 4 🖾 Nursing Ho	me 5□Resi	dence 6 □Oth	er (Specify)	
0	a Physical Seria		27. Menner of Death	28e. Date of Injury (Month, Dey Yo	28b. Tin		28c. Injur Wor	y at	28d. Describe	how injury occurr	red	
0	uth. :: After e funer	읉ㅣ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monal, Doy 11	July 1113	М		Yes 2□No				
Division	i or Attending after death. Director: Afte d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	- At home, farn	n, street, fac	tory, office		28f. Location (City or To	Street and Numb	er or Rural Rou	te Number,
ā	d in die	Ĕ	4 Northclae	building, etc. (эрөспу)			24	Ony or 10	wii, State)		
		edicai (29a. Certifier (Check only one) Certifying Physic 2 Medical Examine		amination and/							cause(s)
	ithin the	ğ Z	29b. Signature end title of certifier	and maintri states	-		29c. Licens	e number		29d. Date signe	d (Month, Day.	Year)
	¥ ¥ ₹ 8			4	>		01	2327		1/12/		
	15x1	-					VJ	CJCS		, , , , , , ,	-4	
1	H. K.		30. Name and address of person who com	pleted cause of deat	h (Item 23e) (T - 1	ype, Print)	- L	M. 3	3 04 = :			
45,355	0		Dr. Khalid Wasee 31. Date filed (Month, Day, Year)	32. Registrer's		nagers	LOWN	Maryland	21740			
	Stat Registra		JAN 1 4 200		A.	Ano st	'>					

DHMH 16 Rev 6/95

			Sta	te of Maryland / De		-	•	ble.
			1 - State Registrar	•	Dertificate of		0.0	004 02683
	Physici	an	Decedent's Name (First, Middle, Last)			Mont		3. Time of Death
	/Medic	al	Ethel Virginia Gi		4h Cihi Tourn	Jan or Location of Death	uay 15,	2004 2:30 p ^M
	Examin	er	4a. Facility Name (If not institution, give street a 8210 Gilroy Road	na numberj				
	Funeral		Social Security Number	7. Age (In yrs. last birth	Nanjen day) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date Hours Min. (Mont	of Birth	9. Birthplace (State or Foreign
	Director		220-32-5204 ^{1□ M 2}	ØF 83 Yr	's. Month's Days	Hours Min. Sept	23,1920	9. Birthplace (State or Foreign Country) Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Maryl -f sho	ţō	Maryland Charles	Nan	jemoy			1 ☐ Yes 2 ☐XNo
	h the or 28a	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of	What Country?
	ath wit	raiD	8210 Gilroy Road		206		U.S.	
	er de: Itams ner m	Funerai	Arr	s Decedent Ever in U.S. ned Forces?	 Was Decedent of H If Yes, specify Cubi 	Hispanic Origin? (Specify Yes an, Mexican, Puerto Rican, etc	or No- 14. Rad c.) Bla	ce - American Indian, ck, White, etc.
39	irs aft	by F	1 Never Married 2 Married 1 If Y 3 Widowed 4 Divorced Ye	Yes 2 No es, Give ar or Dates:	1 ☐ Yes 2🌠 No	Specify:	Specif	y: White
ဝို	within 72 hours atter death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ha Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp	16a. D	Decedent's Usual Occup	pation during most of working	16b. Kind of B	usiness/Industry
7	ithin nan nan nan nan nan nan nan nan nan n	mpie	Elementary/Secondary (0-12) Co	lege (1-4or 5+)	ife. DO NOT use retired	d)		
7	iled w tygier thar th	Co	1 0 17. Father's Name (First, Middle, Last)		Meat Rapp	DET 18. Mother's Name (First, M	Stor	
and	d be f	To Be		nards		Vinnie	_	emarr
Maryland 21215-0036	shoul nd Me mark	ř	19a. Informant's Name/Relationship (Type, Pri		Mailing Address (Street	and Number or Rural Route N		
Š	and 2 alth a 27 Is ar tra		David K. Gilroy,			Rd., Nanje	moy, Md.	20662
Baltimore,	of He of He Mitam or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	20b. Place of D cemetery,	Disposition (Name of crematory or other place	Date		- City or Town, State
Ē	t. Pag tment tant: ijury o		`4 ☐ Donation 5 ☐ Other (Specify)	Trinit		al Jeardens 20	Waldo	rf, Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Items 23a or 28a-f show any injury or othar traumatic event, the Medical Examinat must be notified at Once.		21. Signature of Funeral Septice Liambsee	M00668	22. Name and Addre	s Funeral Ho	ome, P.A.	20640
	- 14		23a. Part1. Ente-the disease, or complications shock, or heart failure. List only one cause		42/0 Haw t enter the mode of dyir	thorne Rd.,	Indian tory arrest,	Approximate
	Pnysician		Immediate Cause (Final	se on each line.	+			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	oue to (or as a consequence of	auria .			
	Examiner		Sequentially list conditions b. —	Mult	- Infu	I I Jenen	bu .	
	ed sit	Examiner	Sequentially list conditions, ray leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	oue to (or as a consequence of	0			
•	xecut	xan	that initiated events c	due to (or as a consequence of):			
760,	e be executed sician and e burial-transit	cal E	d.					
Box 68	th cer tendin r use	an/N	230. Was decedent pregnant	es, outcome of pregnancy Live birth 2 Fetal death	3 □Ectopic pregnancy	1		ite of delivery
П	e dea the att	sici	In the past 12 months?	Pregnant at time of death	5 ☐ Other (specify) _		MC	onth Day Year
Division of Vital Records, P.O.	that the	by Physician/Medi	Part II. Other significant conditions contribution	na to death but not resulting in a	he underlying cause giv	ven in Part I. 23e.	Did tobacco use cont	tribute to the cause of death?
ds,	or Attending Physician: The law requires that the death certalica bifer death. Diractor: Atter this certilicate has been signed by the attending ph in by the tuneral director, page 2 should be detached for use as it	d by	Anala dina	luster	Similar	4	1 Yes 2 No	3 Probably 4 Unknown
S	w req	Completed	CITY SOLD		0 0	248.11 24a.	Was an 24b.	Were autopsy findings available
Be	The la te has	mo	1		0-1-1		performed?/	prior to completion of cause of death? 1 □ Yes 2 □ No
Ital	ian: artifica ctor. p	Be C	25. Was case referred to medical examiner?		XIXIIIII	26. Place of Death (Check		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
<u>></u>	hysic this ce al dire	၉	1 ☐ Yes 2 ☐ No Hospita	I _ Inpatient 2 _ ENOutp	atient 3LJ DOA	1er: 4 Nursing Home 5		
UC C	fing P	ion:	1 Natural 5 Pending	Date of Injury 28b. Tin (Month, Day Year) Inju	ury Wor		cribe how injury occur	red .
isic	Attend death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e	Place of Injury - At home, farm		28f. Locat	tion (Street and Numb	per or Rural Route Number,
2	al or / s after il Dira	Certification:	4 Homicide	building, etc. (Specify)		City	or Town, State)	
	a Hospital 24 hours a Funaral etely tilled		29a. Certifier 1 Certifying Physicien:	To the best of my knowledge, on the basis of examination and/	death occurred at the tir	ne, date and place, and due to	o the cause(s) and ma	anner as stated.
	To the Hospital or Attending Physicien: The law requires that the de within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the completely illied in by the funeral director, page 2 should be detached	Medical	one) ar	d manner stated.	29c. Licens			d (Month, Day, Year)
	To Too	-	29b. Signature and title of certifier	ρ		1001009	29d. Date signe	
_			30. Name and address of person who complete	d cause of death (Item 23a) (T		00,001	1 10	- 04
1	254		Henry L. Burke,			Ave, LaPLa	ta, Md. :	20646
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		· · · · · · · · · · · · · · · · · · ·		
	Registr	ar	JAN 2 0 2004	Between He	Coast ,			

			1 - State Registrar	Cer	rtificate of Death	Reg. N	2004 lo.	0200
4	Physical		Decedent's Name (First, Middle, Last)			2. Date of Death Month	ay Year	3. Time of Death
	Physici /Medic		Gerald Ed	ward Goodwin		_	004	4:30P
	Examir		4a. Facility Name (If not institution, give street a	and number)	4b. City, Town, or Location of Death	4	c. County of Death	4.501
#12			13007 Gerry Road		Clinton		Prince Geo	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	r) Count	**
68	- 17 E		Usual Residence of Decedent	0.5		Dec 19, 1	94U New	York
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation		10	d. Inside City Limits
	Mar Be-f st	tor	Maryland Prince Geor	ge's Clin	ton			1 Yes 2 No
	or 284	Director	10e. Street and Number		10f. Zip Code	10g. 0	itizen of What Count	ry?
	15 will will will will will will will wil	a	13007 Gerry Road		20735		United St	ates
	be filed within 72 hours after death with the Maryland ttal Hygiene. I defent than "natural", or items 23e or 28e-f show event, the Madical Exertifical must be rotified at	Funeral	11. Marital Status 12. Wa	ns Decedent Ever in U.S. 13. \ med Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - America Black, White, e	
20	or it	by Fu	_AA If Y	XYes 2⊡ No ′es, Give	1 ☐ Yes 2 ☐ Yes Specify:	,	Specific	
212-0036	hour:			al of Dates.		100	Wn	ite
ς.	n 72 "nai	Completed	15. Decedent's Education (Specify only highest grade comp	oleted) (Give	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	g 166.	Kind of Business/Ind	Istry
7	withi ene. than	Эшс	Elementary/Secondary (0-12) Col	llege (1-4or 5+)			1 10	_
7 0		Ö	17. Father's Name (First, Middle, Last)	Reti	red Information Ag	gency Fe (First, Middle, Maide	ederal Gov	ernment
/land	id be lental ked o	To Be	Floyd Goodwin		Morti	na Coral	,	
	Shou M br	-	19a. Informant's Name/Relationship (Type, Pri	nt) 19b. Mailir	ng Address (Street and Number or Rural		or Town, State, Zip	Code)
Mar	and 2 :sealth ar		Virginia Goodwin (Wife		7 Gerry Road, Clint			
ā,	f Healten		20a. Method of Disposition	20b. Place of Dispo			Location - City or Tov	
Ē	Pages nent of int: If it iry or o		*ABurial 2 ☐ Cremation 3 ☐ Removal *4 ☐ Donation 5 ☐ Other (Specify)	II II DIII State	tion Cemetery		inton, Ma	rwland
saitimore,	E 60 3		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Lee	Funeral H	Iome Inc 6	633 014
ñ	Departi Departi Import any inj		1/1/1/00/04/	400153 A	lexandria Ferry Ro	pad. Clint	on. Marvl	and 20735
	Physician /Medical Examiner Juan J	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of): Due to (or as a consequence of):	structive Pu	moxar	yarstox	Onset and Death
04/89 X0	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	/Medical	IF FEMALE: 23c. If y	es, outcome of pregnancy			23d. Date of deliver	y
.C. B0	requires that the death c een signed by the attend hould be detached for us	Physiclan	in the past 12 months?		Ectopic pregnancy Other (specify)			Day Year
<u>,</u>	s that ned b e deta	by Pr	Part II. Other significant conditions contributing	ig to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
	w requires to been signer should be	q pe	Hypertension			1 Nes	2 □ No 3 □ Proba	biy 4 □Unknown
Hecords	3 10 0	Completed	Atheroscleros	:15		24a. Was an	24b. Were autops	sy findings available pletion of cause of
	The la	mo	111100000000000			autopsy performed?	death?	
VIII		0	25. Was case referred to medical		26. Place of Death ((Check only one)	o 1 ☐ Yes 2	.LI No
	Physician: r this certific ral director,	0 8	examiner? 1 ☐ Yes 2 ☐ Hospital	l: 1 ☐ Inpatient 2 ☐ ER/Outpatien	0.1	-38118-4-1-1-1-1-1	6 ☐ Other (Specify)	
0	g Physe er this	n: T	27. Manner of Death 28a.	. Date of Injury 28b. Time of		d. Describe how inju		
0	nding tth. r: Aft	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	M 1 ☐ Yes 2 ☐ No			
UNISION	or Atte	Certification:	3 Suicide 6 Could not be determined 28e.	. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	Bf. Location (Street a City or Town, Sta	and Number or Rural (Route Number,
_	To the Hospital or Attending PI within 24 hours atter death. To the Funeral Director: After the completely filled in by the tuneral	Medical Ce	(Check only 2 Medical Examplifier: Of	n the basis of examination and/or inv	n occurred at the time, date and place, an vestigation, in my opinion, death occurred	nd due to the cause(d at the time, date ar	s) and manner as stared place, and due to t	ted. he cause(s)
	o the ithin (o the smple	Mec	29b. Signature and little of certifier	d manner stated.	29 License number	29d. D	ate signed (Month, D	ay, Year)
	ک≒٤⊣		1 Telegraphical	les	1)196033		1/19/0	14
1	B15		30. Name and a dress of person who complete John C. Patterson 750		,	arvoland	20735	
- '-	10 10		John C. Taccerson /JU	I Duriallo Moad,	"LOID, CITHLOH, M	л у Отани	20133	

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) JAN 2 1 2004 32. Resistrar's Signature

			1 - For State Registrar Amend Item#10		Maryland 8282/21	d / Depa /04 @	artmen rtificate	t of H	ealth a Death	and M		giene Reg. No. 20	G4	0268
	Physici /Medi		1. Decedent's Name (First, Middle, Las	cia .							2. Date of Dead	Day	Year	3. Time of Death 0858 M
):	Examir	ner	4a. Fecility Name (If not institution, give						Location o	of Death		4c. County		
-	-		Howard County Ger 5. Social Security Number 6. Se		pital Nge (In yrs. Ia	st hirthday)	Co If Under	1 Year	ia If Under:	24 Hrs	8. Date of Birt	Howa		I (C)
	Funeral Director			ÂM 2□F	60	Yrs.	Months	Days	Hours	Min.	July 2	y, Year)	Cour	plece (State or Foreign htry) ba
	yland how		10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
	Ba-f s	Funeral Director	TX Bexar		San	Anton	io						Ì	1 X Yes 2 □ No
	with the or 2	Dire	10e. Street and Number				10f. Zip					10g. Citizen of W USA	hat Cour	ntry?
	leath ns 23	erai	150 Holy Cross	12. Was Deceden	t Ever in U.S	13 1		228	enanio Orio	nin2 /Sne	city Vac or No.	71127	- Amorio	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show among injury or other traumatic event, the Medical Exemplear must be rectified at annote.	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	?] No	1	fYes, spec IXIYes 2				cify Yes or No- Rican, etc.) an	Black Specify:	, White,	
Maryland 21215-0036	72 hou	Completed	15. Decedent's Edi (Specify only highest grad	cation		16a. Deced	kind of wor	k done d	urina most	of worki	na	16b. Kind of Bu	siness/Inc	dustry
12	filed within Hygiene. Sther than "	jdwc	Elementary/Secondary (0-12)	College (1-4or	5+)		ck Dr					m . 1		
5	Il Hygi other	Be Co	17. Father's Name (First, Middle, Last)			114	CK DI			r's Name	(First, Middle,	Truck Maiden Sumame		
ylar	should be nd Mental marked o	To B	Unknown						Unk	nown	ı			
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (7)			19b. Mailin	g Address	(Street a	nd Numbe.	r or Rura	l Route Numbe	r, City or Town, S	itate, Zip	Code)
ē,	t and Health tem 27 other tr		Killian Connerly 20a. Method of Disposition	/ son	20b. Pla	ce of Dispos	Holy (sition (Nam	e of			tonio,	Texas 7		wn State
<u>o</u> E	Pages nent of l		1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	5	^{netery, cren} Fernai	-			1-10	-04			
Baltimore,	permit. Departmimporta Importa any inju		21. Signatule of Funeral Service Licens		/_		. Name and					San Ant tuary I		, TX
_	20E 29		Lennis	UM	mou	× 3:	114 Ct	uleb	ra Rd	., S	an Anto	nio, TX	782	228
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a.	ilner)	mor		of dying	, such as o	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
8760,	k 23	ical Examiner	Sequentially list conditions, if any k-ann underlying cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		s a conseque									
O. Box 6	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal d	eath 3	Ectopic pre Other (spe					23d. Date Mont		ry Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death I	but not result	ing in the un	derlying ca	use giver	n in Part I.			pacco use contrit		e cause of death?
Vital Records,		Completed	Adult' Respira	tory Dis	stres.	5 54	ndr	orr	ie_	_	24a. Was a autops perform	ned? pri	ere autop or to com ath?	sy findings available indicate of 2 No
<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:							(Check only on			
on of	ng Ph fter th meral	ion: To	27. Manner of Death 1 Natural 5 Pending	1⊿Inpati 28a. Date of Inju (Month, Da	ury 2	NOutpatient 8b. Time of Injury		c. Injury a Work?	at	2	e 5 Reside	ence 6 Other	(Specify) I	
Division of	al or Attendi s after death. Il Director: A od in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In building, e	ijury - At hom tc. <i>(Specify)</i>	e, farm, stre			es 2 □N	-	Bf. Location (St. City or Town	reet and Number , State)	or Rural	Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier 1 Certifying Physical (Check only one)	sician: To the best ner: On the basis of and manner st	of examinatio	edge, death n and/or inve	occurred at estigation, i	the time	, date and nion, death	place, ai	nd due to the ca	use(s) and mannate and place, an	er as sta	ted. the cause(s)
	Vwithii To th Comp	Ĭ	29b. Signature and title of certifier				29c.	License	number		29	9d. Date signed (Month, D	ay, Year)
	5		MAD.				1	123	427			Jan 2	2	004
	A property of the second		30. Name and address of person who so	mpleted cause of a	death (Item 2	3a) (Type, P	Print)	arm	en.	Sal	gaterra	MD	(
	Sta Registra	~ 3	31. Date filed (Month, Day, Year) JAN 12 200	32. Registr	rar's Signatur	g	Spa	KS	rola					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ARR 01:20 AM **Physician** WEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mor One 1 Year If Under 24 Hrs. Allegan Ha 8. Date of Birth (Month, Day, Year) 9. Birthplece Country) (In yrs. last birthday) (State or Foreign 5. Social Security Number **Funeral** Days 1 M 2 □ F Months Min. 80 95-18-5191 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ahow or other traumatic event, the Mudical Examiner must be notified at MEYERSALE 1 Yes 2 No SOMERSET Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 05 STATION or Itams 23a 21 by Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 43-4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, While, etc. 11. Marital Status 1 Never Married 2 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Flementary/Secondary (0-12) College (1-4or 5+) FFICE 051 OST MASTER permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Itam 27 la marked other th any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be VANNE ECIL LENAN Town, State, Zip Gode) 15352 MEYERS DALIPA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip dode) DOROT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate Date 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) JA0 17 AUL & mo 22. Name and Address of Facility
IM RAY LECKEMBY FWEEPAL HOME
203 WEFTH ST MEYER 1583 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MAYERS DINE Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Adenocarcinoma **Physician** mos /Medical Examiner Pleira ilateral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit death certificate be executed engestive resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No this certificate has page 2 1 ☐ Yes or Attanding Physician: filled in by the funeral director, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 ER/Outpatient 1 Yes 2 No 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation To the Hospital or Attanc within 24 hours after death To the Funaral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 15,2004 January Chauns 11

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 6 2004

Dr. John Menauna

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sports!

Drive Cumberlaus,

nLS

SETON

			For State Registrar	State	of Maryland		artment rtificate			and M		giene . 1eg. No. ¹	2004	021	688
			1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	ith Day	Year	3. Time of	Death
	Physicia /Medic		Anna		Malen	a	H	lanso	n		Januar			1350	P M
	Examin		4a. Fecility Name (If not institution	n, give street and n	ımber)		4b. City,	Town, or	Location of	of Death		4c. (County of Deat	h	
			Allegany Count	y Nursin	g & Reha	b. Ctr			erla				Allega		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗓 F	7. Age (in yrs. la		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day	, Year)	9. Birt	hplace (State o nuntry)	or Foreign
	Director		516-36-2291	TO WE ZUALF	94	Yrs.					07/29/	1909	Mo	ntana	
	pur *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside C	ity Limits
	sho sho	5		legany			ntsto	ne						1 ☐ Yes	2 X No
	the N	Directo	10e. Street and Number	regarry		1 1 1	10f. Zip					10g. Citiz	en of What Co	untry?	
	with with	흡		0	. D 1	NI E		2153	ο Λ			_	USA		
	eath	Funeral	21406 Flintst	12. Was De	cedent Ever in U.	S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No-	1	4. Race - Ame		
	fler d	표	1 ☐ Never Married 2 ☐ Marri		2 📉 No	1	If Yes, spec			i, Puerto i	Rican, etc.)		Black, Whit	e, etc.	
ğ	urs a	à	3 ₩ Widowed 4 Divorced	If Yes, G Year or	iive Dates:		1 🗌 Yes	2IAJ No	Specify:				Specify:	Nhite	
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28e-f show ha Marical Ezani ner must te rolified al	Completed	15. Deceden (Specify only highe	t's Education	n		dent's Usua kind of wor			t of workir	na	16b. Kin	d of Business	Industry	
21	e e e	ple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT us	se retired,)		•			•	
ณ	filed wi Hygien Sther th	S	12	11		-	Nurs	se	40 44-45		(First Middle		Health	Care	
2	d oth	Be	17. Father's Name (First, Middle,		1	T 1					(First, Middle,	маюел з hris		Sandv	0
<u>₹</u>	2 should be filed within 72 hours after death with the Marylan and Menhall Hygiene. and Menhall Hygiene is marked other than "naturat", or items 23a or 28e-f show eumetic event, the Medical Examinat must be notified at	은	Bernt	Herredsv	ета	_	nson	(2)	E11						
-			19a. Informant's Name/Relations			1	•				I Route Numbe	-			D 2 1 5 2 i
	1 and 3 Health em 27		Allene M. Teete	er / daug	hter						k Rd.,		rilints1 ation - City or		DZ133
	Pages 1 nent of h nnt: If ite ury or ot		1XXBurial 2 Cremation		n State	lace of Dispo emetery, crei				_					
	permit. Pages Department of Importent: If it any injury or o		`4 □Donation 5 □ Other (S		Gle	ndale	Cemet 2. Name an	terv			9/2004_				D 4
Ba	Depar Depar Impor any ir		21. Signatur) of Fureral Service	Licensee	1	, ''				110	ams Fam				
	402 # Q		23a. Part1. Enter the disease, or	, Ul	coursed the death	Do not on					reet, C		rland,	Approxima	.502
			shock, or heart failure. List	only one cause on	each line.	i. Do not en	ter the mod	e or dying	y, such as	Cardiac	i i i i i i i i i i i i i i i i i i i	1031,		Interval Bel Onset and	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)		piration		nonia							5 do	us.
	/Medical Examiner		1650tting in Goztin		o (or as a consequ									-	
		-	Sequentially list conditions, if any, leading to immediate		vere Dem									5 ye	ans
	ed	Examiner	Cause (Disease or injury	< − − − − − − − − − − − − − − − − − − −	5 (0. 40 4 50504.										
	and and	xar	that initiated events resulting in death) Last	c	o (or as a consequ	uence of):									
8760,	ate be executed hysician and the burial-transit	Icai E													
387	icate phys s the			0.											
Box 6	Attanding Physicien: The law requires that the death certificate be executed rideath. rideath. ector: Atter this certificate has been signed by the attending physician and better this certificate as been signed by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna							2	3d. Date of de	livery	
ă	atter 1 for	ciar	in the past 12 months?	4□Pre	birth 2 🗍 Fetal gnant at time of de		⊒Ectopic pr ⊒ Other (sp						Month	Day	Year
<u>о</u> .	that the de led by the a detached t	hysi	9 Unknown	9□ Unl	nown										
σ.	res that signed to be deta	by P	Part II. Other significant conditi								23e. Did to	obacco us	se contribute to	the cause of	death?
g	n sig	D D	Severe COPD w	/Anoxia,	Alzheime	er's D	iseas	e, C	.A.D.		1 🗆 Y	′es 2[]No 3∏P	robably 4 🔀	Unknown
Ö	s been si should	Set									24a. Was	an	24b. Were a	utopsy findings	available
æ	he lav e has age 2	Completed									perfor	rmed?	death?	completion of a	00000
<u>ra</u>	ifficat	a)	25. Was case referred to medica	ıl					26. Place	of Death	(Check only o				
>	ysicie s cer direct	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DC	Othe	er: 4XXNL	ırsing Ho	me 5 🗆 Resid	dence 6	Other (Spe	icify)	
Division of Vital Records,	g Phy er thi	i.	27. Manner of Death		e of Injury onth, Day Year)	28b. Time o	of 2	28c. Injury Work			28d. Describe h				
ion	ndin ath. r: Aft	읉	1 Natural 5 Pendi 2 Accident invest	igation (A)	min, buy . bu.,	,,	М		Yes 2	No					
<u>Vis</u>	Atte	ij	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	nined 200. Fia	ce of Injury - At ho		reet, factor	y, office			28f. Location (5 City or Tox			ural Route Nur	nber,
Ö	s afte	Certification:			g, (-,,										- 1
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical (29a. Certifier 1 Certifyi	ng Physician: To t I Examiner: On the	he best of my kno	wledge, dear	th occurred	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the e	cause(s) date and	and manner a	s stated. a to the cause(s)
	he H in 24 he F iptete	edi	one)	and ma	nner stated.										
	Vith To 1	Σ	29b. Signature and title of certific	er .] D			290		e number				e signed (Mon		
•	1		V. H. Ka	Mitha	Λ			D1	9750			Jan	uary 1	6, 2004	+
	0 0 A		30. Name and address of person	who completed ca											
(1120		Vimala A. Ran				dtown	Roa	d, Cı	ımber	land, M	1D 2	21502		
	Sta		31. Date filed (Month, Day, Year JAN 2 0 2	2004	Registrar's Signa	ture /	100	. 11	,						
	Regist	ar	01111 20 2	.007	*	1	1300	12							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2004 Hilda Armatha Houser January 14, 3:35 PM 4b. City, Town, or Location of Deeth 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth Coffman Nursing Home, Hagerstown Washington If Under 1 Year 8. Date of Birth (Month, Dey, Year) April 12, 1 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Deys 1 □ M 2 X F Months 81 218-74-1708 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1304 Pennsylvania Avenue 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jesse Herman Houser Rebecca Elizabeth Grimm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Houser - Nephew 250 Linganore Ave. - Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Samples Manor Cemetery 1/17/04 Sharpsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eackles-Spencer Funeral Home 21. Signature of Funeral Service Licenses M 970 Harpers Ferry, WV 25425 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death eleve opper respectacy///NESS: pesserele Immediete Ceuse (Final disease or condition resulting in death)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Madical Examiner must be notified at

Baltimore, Maryland 21215-0020

/Medical

10a. State

MD

Director

Funeral

þ

Completed

Be

ပ

Medical Certification: To Be Completed by Physician/Medical Examiner
minities. The forms and reference after this certiticate has been signed by the ettending physician and completely filled in by the tuneral director, page 2 should be deteched for use as the buriel-trensit
To the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Due to (c	or as a consequence of	S:	1	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	b. Due to (c	or as a consequence of):		
Cause (Disease or injury that initiated events resulting in deeth) Lest	c. Due to (o	or as e consequence of)	:		
_	d				
Part II. Other eignificant conditions of	ontributing to death but not res	ylting in the underlying	cause given in Part I.	23b. Did tobacco uee co 1 ☐ Yes 2 ☐ No	ntribute to the cause of death? 3 Probably 4 Unknown
Mensof	retarati	or		24a. Was an autopsy performed?	24 Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ D	OA Other: 4X Nursing	Home 5□ Residence 6 □Oth	er (Specify)
27. Menner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occur	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, facto	ry, office	28f. Location (Street and Numb City or Town, State)	per or Rural Route Number,
29a. Certifier (Check only one) Certifying Ph	ysiclen: To the best of my kno niner: On the basis of examina end manner stated.	wledge, death occurred tion end/or investigation	d at the time, date and plac n, in my opinion, death occ	e, and due to the cause(s) and ma urred at the time, date and place,	anner as steted. and due to the cause(s)

166

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUL

32. Registrar's Signature

FM (19

JAN 16

Funeral

Director

Show

direct rust be notified at or Itams 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: the Medical Exam Completed by 3 X Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) othar than Elementary/Secondary (0-12) College (1-4or 5+) 10 permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie.
Important: If Itam 27 Ia markad other tl
any injury or other traumatic evant, Itae EXPEDITER 17. Father's Name (First, Middle, Last) Be CHARLES E. HARMON 19a. Informant's Name/Relationship (Type, Print) DENNIS W. HUTZELL/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) BOONSBORO CEMETERY 21. Signature of Fune all Service Linensee 22. Name and Address of Facility BAST FUNERAL HOME Paul M. Dean 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician Preumoma /Medical Due to (or as a consequence of): Examiner Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cornery Due to (or as a conseque e of): Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an Demente 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number D44996 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 14, 2004 **Physician** 3:15 P M January HUTZELL **VIRGINIA** MAE /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REEDERS MEMORIAL HOME WASHINGTON BOONSBORO If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Days 1 ☐ M 2 🛛 F Yrs JULY 29, 1924 79 215-20-8779 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1XIYes 2 □ No Funeral Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 112 SOUTH MAIN STREET 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: Specify: WHITE 16b. Kind of Business/Industry AIRCRAFT MANUFACTURING 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH KATHERINE HILL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 NORTH MAIN STREET, BOONSBORO, MARYLAND 21713 20c. Location - City or Town, State 1/17/2004 BOONSBORO, MARYLAND 7606 Old National Pike Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death 2 weeks 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2□ No 2 12 No 1 Tes Other: 4 Jursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dav. Year) 14,2004 Lappans Road, Boonsboro, Maryland 21713 / 301-432-8470 Dr. Zafar Halik 20311 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar

			For 1_ State	State of Maryland / Dep		Health and N	Mental Hygi	ene 2004	02691		
			Registrar 1. Decedent's Name (First, Middle, Last)		Tuncate or	Dealli	2, Date of Death	g. No.	3. Time of Death		
	Physici	an		HUGHES			Month	Day Yeer			
	/Medic		4a. Facility Name (If not institution, give st		4b City Town o	or Location of Death	Vanuary	4c. County of Death			
	Examir	er	WASHINGTON COUNTY			HAGERSTOW			INGTON		
	Funeral			7. Age (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		optece (State or Foreign untry)		
	Director		219-52-1600 Usual Residence of Decedent	M 2□F 57 Yrs.	Months Days	Hours Min.	NOV. 16,	, 1946 I	MARYLAND		
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ahow ha Madical Evainting Fitual be invilled at		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits		
	a-f a	ctor	MARYLAND WASHIN	GTON	В	OONSBORO			1 ☐ Yes 2 No		
	or 28	Funeral Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cou	untry?		
	23e	ai	17827 BAKERSVILLE			21713			S.A.		
	r dea	Inel	11. Marital Status	Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
36	or II	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 2X No	Specify:		Specify:			
8	hour	D	3 Widowed 4 Divorced	Year or Dates:	adant's Houst Ossue	nation .	14		WHITE		
4	"nat	iete	15. Decedent's Educ (Specify only highest grade	completed) (Give	edent's Usuat Occup is kind of work done DO NOT use retire	during most of work	king	6b. Kind of Business/li	ndustry		
21215-0036	withi ene. than	Completed	Elementary/Secondary (0-12)	Cottege (1-4or 5+)	disab		-	DISABLEI	D		
	filled Hygi ther ant,		17. Father's Name (First, Middle, Last)		albab	7	e (First, Middle, Ma		<u>, </u>		
an	d be antai	To Be	DONALD EUGENE HUGH	HES		PAULIN	E ELIZABE	ETH POFFENI	BERGER		
Maryland	should be filed and Mental Hygi is marked other surnatic event, it	F	19a. Informant's Name/Relationship (Typ		ing Address (Street	<u> </u>		City or Town, State, Zi			
S	nd 2 ith al 27 is r treu		ROBIN KIFER, SISTI	ER 2102	27 BLACK	ROCK ROAD	, HAGERST	COWN, MARYI	LAND 21740		
<u>ē</u>	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f ahov other treumatic event, the Medical Examble trush be invitibled at		20a. Method of Disposition	20b. Place of Disp	osition (Name of ematory or other pla		Date 20	Oc. Location - City or T	fown, State		
9	90 = 5		1 XBurial 2 ☐ Cremation 3 ☐ Re 14 ☐ Dopation 5 ☐ Other (Specify)	moval from State	ILLE CEME		17, 04 H	BOONSBORO,	MARYLAND		
Baltimore,			21. Sign kure of huneral Service Lib nser	9 2	2. Name and Addre			National Pike			
ä	permit. Departr Imports any inju		Day VML Jan	Paul M. Dean PA	ST FUNER			oro, Maryland 21713			
	to the		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do not en	iter the mode of dy				Approximate Interval Between		
	Physician		tmmediate Cause (Final	mokachalic	, benil	1 /	or		Onset and Death		
•	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	100110	e carre			6 MONTAL		
-	Examiner										
	7	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):							
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events c.								
o,	en ar	Ä	resulting in death) Last	Due to (or as a consequence of):							
3760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	cai	€ d.								
89	leath certificate t attending physicater of the terms of	by Physician/Medi	tF FEMALE:				· · · · · · · · · · · · · · · · · · ·				
Вох	th ce tendi	an/	23b. Was decedent pregnant	lc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnanc	y		23d. Date of deliv			
	dea deatl	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5 9 Unknown	Other (specify) _			Month	Day Year		
P.0	uires that the de: signed by the a id be detached f	Phy	9 🗆 Unknown								
	es th igned	b	Part II. Other significant conditions conf	tributing to death but not resulting in the t	underlying cause gr	ven in Part I.		icco use contribute to	the cause of death?		
ord	w require been si should I	ted	10.01	ionant plans	1 011.	(0 (0 10	1 🗆 Yes	2 MENO 3 Pro	bably 4 Unknown		
Records,	law r as be	pfe	mali	gran pausa	1 444	5100	24a. Was an autopsy	prior to co	topsy findings available ompletion of cause of		
000	ilcian: The lar certilicate has rector, page 2	Completed	HYL	restension			performe 1 ☐ Yes 2	ed? death? No 1 ☐ Yes			
of Vital	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?	1			th (Check only one)	1			
5	Physic this or al dire	ို	TE TOS ZELOTO	ospital: 1 postient 2 EP/Outpatie	HIL SLI DOA			ce 6 Other (Speci	ity)		
_	ding P	e e	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	Wo		28d. Describe how	rinjury occurred			
Division	l or Attendi after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□No					
Ξ̈́	or Att	E	4 Homicide determined	28e. Ptace of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	'al Route Number,		
	To the Hospitel or Attending Physicien: The lawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Ce									
	Hosp 4 hol Fune tely fi	Medical	(Check only 2 Medicet Examin	ician: To the best of my knowledge, dea er: On the basis of examination and/or in							
	the the	Med	one) 29b. Signature and title of certifier	and manner stated.	29c Licen	se number	n 290	Date signed (Month)	Day Veer 1		
	T Will		255. Signaturo antoquio of continor	12	D4	4996	5	Jan. 14	2004		
	3		***************************************	<u> </u>	200	(' /	, 10				
اط	1,		30. Name and agoress of person who cor	mpleted cause of death (Item 23a) (Type	Mil Lap	nans R	4 1500m	Sbozo M	D2/7/3		
نب	Sta	ato.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	al [®]						
	Regist		JAN 16 200	4 Dien D. B	ad when the						

			1 - For State Registrar	State of Ma	ryland / De <i>C</i>	partmei <i>ertifica</i>	nt of H	lealth a Death	and M	lental Hy	giene	104	026	92
	Physici	an	Decedent's Name (First, Middle, Landson Middle) DEDUITA Management	,						2. Date of De Month	eath Day	Year	3. Time of	_
	/Medio	cal	BERTHA M. 4a. Facility Name (If not institution, gi	HARRINGT	ON	4h Cih	Town	r Location o	of Dogsth	JAN.		2004 ty of Death	2:30	Рм
	Examir	ier	SUNBRIDGE CARE C			40. 049	ELKT		oi Deatii			CIL		
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthda	y) If Unde	r 1 Year		24 Hrs. Min.	8. Date of Bir (Month, Da	rth .	9. Birth	olace (State or	Foreign
	Director		173-20-4495	1□M 2X)F	76 Yrs.	Months	Days	Houis	Min.		0,1927	PEN	NSYLVAI	NIA
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						1.	IOd. Inside Cit	v I imits
	Mary	Ş	MD CECIL		ELKT	ON							1 ☐ Yes	•
	h the	Director	10e. Street and Number				p Code				10g. Citizen of	What Cou	ntry?	
	hours after death with the Maryland turel; or Items 23a or 28a-1 show al Examinat must be redified at		2125 BARKSDALE	RD.			219	21			USA			
	er dez	Funeral	11. Marital Status	12. Was Decedent Example Forces?		3. Was Dece If Yes, spe	dent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.))- 14. Ra Bla	ce - Americack, White,		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 🗆 Yes	2 K) No	Specify:			Speci	fy: WH	ITE	
9200-91212	be filed within 72 hours after death with the Marylan delth tygiene. dath tygiene. dath than "neturel", or items 23a or 28a-1 show event, The Medical Examiner must be rediffed at	ted	15. Decedent's E	ducation	16a. De	cedent's Usu	al Occupa	ation			16b. Kind of E			
2	ithin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+	lite	ve kind of wi DO NOT u	ork done d ise retired	during mosi I)	t of worki	ng				
2	filed within 72 Hygiene. Ither than "nel ent, the Medic	S	10th			BOOK	KEEP					TRY C	LUB	
Maryland	ild be fi fental F rked ot	Be	17. Father's Name (First, Middle, Las. JOHN KUBANY	0						WISE	, Maiden Suma	тө)		
2	d 2 should th and Men 17 is marke treumatic	Ţ.	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Addres	s (Street a				er, City or Town	State Zin	(Code)	
	2 4 5 5		W. JAY HARRINGTO	N - SON		SWART					DE 197		3000)	
w	- T - =		20a. Method of Disposition 1		20b. Place of Dis	position (Na	me of	1 -		ate	20c. Location		wn, State	
Ĕ	Pagement ment ent: i		'4 □ Donation 5 ② Other (Speci	(y) /	W. NOTT				AN.2	2,2004	COLOR	RA, MI) .	
Baitimore,	permit. Pages Department of I Importent: If ite any Injury or o once.		21. Signature of Fullery Strvice Like	nsee		22. Name a SPICER	nd Addres -MUL]	s of Facility	y FUN	ERAL HO	MES, IN	IC.		
	40260		232. Part 1. Enter the disease, or con	rollications that caused h		.000 м	• DUI	PONT .	PKWY	., NEW	CASTLE.	DE.	19720	
	N		shock, or heart failure. List only	one cause on each line	doain. Do not	lie me no	Je or dying	y, such as	cardiac o	r respiratory a	rrest,		Approximate interval Betwo Qnset and De	een
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	1 5		an					1 Tyr	~~~
	Examiner		Construction lies and distance	2	in 1	leto	ارم	-03	, (<				1+ VF	
	Q #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or):								•	
	and and I-trans	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):									
Ω Q / Ω	ficate be executed physicien and s the burial-transit	dical E		300 (0) (0) 43 4	3011304431130 317.									
200	certificate be execu nding physicien and use as the burial-trar	0		d										
ŏ	ih cert endin r use	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		□Ectopic p	raananau				23d. Da	ite of delive	ry	
ם י	e death he atten ed for u	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at tir		Other (sp					Mo	onth	Day Ye	ar
r.	hat the d by t detach	Ph.	9 ☐ Unknown Part II. Other significant conditions		not socialize in the	on and a set than a		- i- O i		000 000		1-21- 1- 1- 11		
ďŠ,	w requires that the death certific been signed by the attending p should be detached for use as	۵	Part II. Other significant conditions	contributing to death but	not resulting in the	unaeriying o	ause give	n in Part I.			obacco use con res 2 □ No	tribute to th 3 □ Prob		_
	w requ	Completed								24a. Was				
ב ב	nysicien: The law his certificate has b I director, page 2 sl	d Lic								autop	rmed?	prior to con death?	osy findings av	use of
		ø	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes Check onl o		1 🗆 Yes	2 DN0	
>	rnysici this ce al direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🔲 Inpatient	2 ER/Outpati	ent 3 DC	Othe		_		lence 6 Oth	ner (Specify)	MI -
	Ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Time Injury		8c. Injury Work	at ?	2	8d. Describe h	ow injury occur	red		
IVISIO	death death stor: /	icat	2 Accident investigatio 3 Suicide 6 Could not b	e Oga Dinas of Ising	At home form	M		′es 2□N		Of topotion (C	· · · · · · · · · · · · · · · · · · ·			
5	efter e	Certification:	4 ☐ Homicide determined	28e. Place of Injury building, etc.	(Specify)	treet, factor	, office		2	City or Tow	itreet and Numb n, State)	er or Rural	Route Numbe	er,
_	io the nospitel of Attending Physicien: within 24 hours elicated and in 24 hours elicated and in 24 hours elicated and in 25 the Completely filled in by the funeral director,		29a. Certifier 1 Certifying Pt	nysician: To the best of	my knowledge, de	ith occurred	at the time	e, date and	place, a	nd due to the d	cause(s) and ma	anner as sta	ated.	
	in 24 in 24 in Fu	Medical	(Check only 2 Medical Examone)	niner: On the basis of each manner state	xamination and/or	nvestigation	, in my opi	inion, death	h occurre	d at the time, o	date and place,	and due to	the cause(s)	
ı	To t	Σ	29b. Signature and title of certifier			290	. License	number			29d. Date signe	d (Month, L	Day, Year)	
	,		Colonia		- M		006	7 -	40	7	1119	104		
	6		30. Name Ind address of person who	completed cause of dea	th (Item 23a) (Type	Print)		l W. H KTON,						
ž.,	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature		ELL	(TON)	LID A	- I J C I				
	Registra		JAN 2.0 2004 /	so M	house ,									

			1 - For Registrar	State of Maryland /		artment of I		Menta		ene . No 2004	02693
	Physici	an	Decedent's Name (First, Middle, Last))				Mo	ite of Death onth	Day Year	3. Time of Death
	/Medic Examin	al	Judith Ogden Henry 4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of De		nuary	13, 2004 4c. County of Dea	3:40 a.m ^M .
	LAdillii	C1	500 Piney Creek Fa	rm		North				Cecil	
	Funeral Director		5. Social Security Number 6. Security Number 127-01-7687 Usual Residence of Decedent	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		in. 8. Da /M Mai	ite of Birth Jonth, Day, 1 rch 27	(ear) 9. Bir Co	thplace (State or Foreign ountry) New York
	Maryland I show	tor	10a. State 10b. County Maryland Cecil	10c. City, To		cation th East					10d. Inside City Limits 1 ☐ Yes 2XXXII
	or 28a	Funerai Directo	10e. Street and Number			10f. Zip Code				g. Citizen of What Co	•
	sath w	erail	500 Piney Creek Fa	rm 12. Was Decedent Ever in U.S.	13.1	2190 Was Decedent of		(Specify V		nited Sta	
936	al', or Item	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Amed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1	if Yes, specify Cub	oan, Mexican, Pu	erto Rican,	etc.)	Black, Whit	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinational be morified at angle.	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	dent's Usual Occu kind of work done DO NOT use retire Teacher	during most of ved)	vorking	16	Sb. Kind of Business Educat	
ر 2	e filed il Hygi other vent, II	Se Cc	17. Father's Name (First, Middle, Last)			1000101	1	lame (First	, Middle, Ma	iden Sumame)	
ylar	should be and Mental marked o	To	George B. Ogden					Bryaı			
Mar	d 2 shu th and 17 le m traum		19a. Informant's Name/Relationship (T) Louise Henry Kamih								Zip Code) 22305 Virginia
	s 1 and of Health item 27 other tr		20a. Method of Disposition	20b. Place		sition (Name of natory or other pla		Date uary	20	c. Location - City or	
Baltimore,	Pages ment of I lant: If its jury or o		1 ☐ Burial 2 【Cremation 3 ☐ F '4 ☐ Donation 3 ☐ Other (Specify)	temoval nom State	rdal	e Cremat	ory 200			lewark, De	laware
Ball	permit. Departr Imports any inj		21. Signature of Funery Service Cons	99		Name and Addr 7 South				eral Home East, Ma	e ryland 21901
	Pnysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		ces	er the mode of dy	ing, such as card	liac or resp	iratory arres	t,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions,	D							
	ned Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):						
8760,	icate be executed physician and s the burial-transit	icai Exa	that initiated events resulting in death) Last	Due to (or as a consequence	ce of):						
Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	ath 3	Ectopic pregnand Other (specify)	cy			23d. Date of de Month	livery Day Year
rds, P.	quires that n signed by uld be deta	þ	Part II. Other significant conditions co	ntributing to death but not resultin	ig in the u	nderlying cause g	iven in Part I.	_	3e. Did toba		o the cause of death?
Division of Vital Records, P.O.	Physician: The law requir this certificate has been si al director, page 2 should	Completed						-	4a. Was an autopsy performe □ Yes 2	prior to	utopsy findings available completion of cause of
Vita	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of I				
on of	Jing J. After fune	tion: To	1 Yes 2 No ' 27. Manner of Death Natural 5 Pending 2 Accident investigation	1 Inpatient 2 EH/	Outpatier b. Time o Injury	f 28c. Inju	4 IAMI 2111			ce 6 Other (Spe	cify)
Divisi	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	reet, factory, office			ocation (Stre ity or Town,	et and Number or R State)	ural Route Number,
	the Hospital or hin 24 hours after the Funerel Dir upletely filled in	Medical (sician: To the best of my knowled ner: On the basis of examination and manner stated.							
	To the vithir To the comp	ž	29b. Signature and title of certifier				ise number		290	d. Date signed (Mont	h, Day, Year)
	nn		30. Name and address of person who co	numbered cause of death /Item 23	la) (Type	D59			(11-13-()/
_	XU		JAmil Khatri M	D, 111 W. H.	96	ST, # 104,	ElKt	on,	MD	21921	
	Sta Regi sti		31. Date filed (Month, Day, Year) JAN 1 5 2004	32. Registrar's Signature	all of	, ,		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 11 **Physician** 2ďď4 9:22 P M ARNOLD HUGHES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 158 FARM ROAD Aberdeen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Nov. 27, 1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funera! Days Months Hours 1X M 2□ F 73 Alabama 401-54-5569 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23s or 28s-1 show other treumstic event, the Madical Examiner must be notified at 1 ☐ Yes 2X No Director Aberdeen Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21001 USA 158 Farm Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Amed Folces.

1 X Yes 2 No
If Yes, Give
Year or Dates: unknown 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black \$ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Material Classifier US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Herman Hughes Mabel Jones inveld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health P.O. Box 0172, Santa Rosa, New Mexico 88435 Emory Crawford / stepson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Itel any injury or ott 1 Daurial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Grds. 1/17/04 Aberdeen, Maryland 22. Name and Address of Facility
Lisa Scott Funeral Home, P.A. 21. Signature of Funeral Service Licensee Joett 552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nu **Physician** Ocarda /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2□ No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No ဥ 3□ DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) he Hospitel or Attending P. n 24 hours after death. he Funerel Director: Atter th 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Natural 2 Accident 5 ☐ Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide TSI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the within 2

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and

Anast

29c. License number

29d. Date signed (Month, Dev. Year)

Kunuaru

2004

	1	For Amend Items 25	State of 19d per Di	Maryland	/ Dep: 2/02/02	artment of H	lealth a	and Mei	ntai Hyg	iene eg. Ng2 () () (1 02695		
		I. Decedent's Name (First, Middle, La				· · · · · · · · · · · · · · · · · ·			Date of Deat	th	3. Time of Death		
Physicia		MARGARET J	OANNA	HUNTER	>			.	Month IANUAF	Day Ye	l A		
/Medica Examine		a. Facility Name (If not institution, gi				4b. City, Town, or	Location of		ANUAL	4c. County of D			
Examine	1	Chester River			ter	Cheste	rtow	n		Kent			
Europol				7. Age (In yrs. las		If Under 1 Year	If Under	24 Hrs. 8.	Date of Birth	9.	Birthplace (State or Foreig		
Funeral Director			1 □ M 2120 F	95	Yrs.	Months Days	Hours	Min.	(Month, Dey, Year) Country) Aug 25 1908 Maryland				
	_	Jsual Residence of Decedent				1		A	ug 25	1300114	агутани		
Maryland -I show		10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits		
with the Maryla or 28a-f sho	ថ្ង	MD Kent		Che	este:	rtown					tyETYes 2□No		
r 28a-1	<u>e</u>	10e. Street and Number				10f. Zip Code			1	0g. Citizen of What	t Country?		
ms 23a or	2	108 S. Lynchbu	ıra St.			2162	20			U.S.A.			
ter death	<u> ≃</u> ⊢	11. Marital Status	12. Was Deced	dent Ever in U.S.	. 13.	Was Decedent of Hi If Yes, specify Cuba		gin? (Specify	Yes or No-	14. Race - A	American Indian,		
after or Ite	크	1 Never Married 2 Married	Armed For	2 ∏ No				i, Puerto Ric	an, etc.)		Vhite, etc.		
030 urs a	۵	3 Nidowed 4 Divorced	If Yes, Give Year or Da	tes:		1 ☐ Yes 2 🔀 No	Specify:		19	Specify:	White		
21215-0036 ad within 72 hours all giene. er than "naturel", or it, the Medical Exam	Completed	15. Decedent's E				dent's Usual Occupa		A = 6 = dei= =		16b. Kind of Busine	ess/Industry		
March 7	<u> </u>	(Specify only highest gi	College (1-	4or 5+)	life.	kind of work done of DO NOT use retired	juring mos i)	t of working					
212 d within giene. or than	E	6	College (1-	401 34)	Ρā	cker				Chemica	al Company		
laryland 212: 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Men	0	17. Father's Name (First, Middle, Las	t)				18. Mothe	r's Name <i>(F</i>	irst, Middle, M	Maiden Sumame)			
ad be senta ked	0	Thomas Minch					Mar	garet	U 11 n	nan			
ore, Maryland es 1 and 2 should be file of Health and Mental Hy fitem 27 is merked oth r other traumatic event		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a	and Numbe	or or Rural R	oute Number,	City or Town, Stat	te, Zip Code)		
Magarant and 2 and 2 and 27 is 27 is 1 trau		Margaret Robi	nson (d	daughte	r) 3	30 Rive	r Rd	. Che	stert	own, MI	21620		
Head Head	1	20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of		Date		20c. Location - City			
De la gent de la company de la		Durial 2 ☐ Cremation 3				natory or other plac Hill Ce	e) m . 1	1/9/0	4	Church	Hill, MD		
ting the standard signs of the standard sign		 4 ☐ Donation 5 ☐ Other (Special) 21. Signature of Funeral Sector Lice 	-	0110			- i						
Baltimore, permit. Pages 1a Department of Hee Important: If tem any injury or othe		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	V	M0051	.0 1	<u>18 West</u>	Cro	ss St	. Gal	Lena, MI	en L Schae		
b, executed in and rial-transit	aminer	disease or condition resulting in death) Sequentially list conditions, land land cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a conseque	nce of			ucle					
Box 6 sath certif	₹ [IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live bir	come of pregnand th 2 □ Fetal d ant at time of dea wn	eath 3[Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day Year		
S, es ti	<u>ה</u>	Part II. Other significant conditions	contributing to dea	ath but not result	ing in the u	nderlying cause give	en in Part I.				e to the cause of death?] Probably 4 □Unknowr		
Re far te has age 2	Completed								24a. Was ar autops perform 1 Yes 2	y prior ned? death	e autopsy findings available completion of cause of 1? Yes 2 \sum No		
Vital Fician: The certificate ector, page		25. Was case referred to medical					26. Place	of Death (C	heck only on				
Of Vita Physician: this certific al director,	0	examiner? 1 ☐ Yes 2 █️No	Hospital: 1 110	patient 2 E	R/Outpatier	nt 3 DOA Othe	er: 4□ Nu	rsing Home	5 ☐ Reside	ince 6 Other (5	Specify)		
Of Phys ar this aral di		27. Manner of Death	28a. Date of		8b. Time o	28c. Injury	at			w injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Vision (Attending Pattent) sctor: After by the funer.	를	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		i, Day Year)	Injury	Work M 1□	r Yes 2 🔲 i	No					
trendii death. ctor: A y the fu	2	3 ☐ Suicide 6 ☐ Could not		of Injury - At hom	e, farm, sti	eet, factory, office		28f.			Rural Route Number,		
Division of Vital To the Hospitel or Attending Physician: I within 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, p	Certification;	4 Homicide determined	buildin	g, etc. (Specify)	, , , , , , , , ,				City or Town				
pitel urs au lied		On Carting 15 Tradition D	busislana Tarka					d =1000 00d	d				
Hosp 24 ho Fune Fune	Medical		miner: On the ba	sis of examinatio		n occurred at the tim vestigation, in my op							
the the mple	Ş -		and mann	er stated.		29c. License	number		20	ad Date signed (M	onth Day Vest)		
To To con		29b. Signature and title of certifier				Zac. License	- Hullider		25	od. Date signed (M 01/0	0/1004 (1997)		
		Vil C A	9/1	nus		0-0013	824			St 1 5	-cocy		
4		30. Name and address of person who	completed cause	of death (Item 2	23a) (Type,	Print)							
T		John C. Sevm	our MI	122	Spe	er Rd.	Ches	terto	wn, M	ID. 2162	20		
State	е	31. Date filed (Month, Day, Year)	€2. Re	gistrar's Signatu	гө 🥒	A0 .							
Registra	r	FEB 0 2 200	4 Des	we do	E TO	and the second							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Physician Elsie Mildred Judd-Schuffert January 17, 2004 8:25 AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany County Nursing & Rehab. Center Cumberland Allegany If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 □ M 2 🛛 F Yrs. 220-03-7742 92 Director 10/11/1911 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits entnent of Heelth and Mental Hygiene. ortant: if itam 27 is marked other then "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 To No Directo Bedford Bedford 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 663 Pine Ridge Road 15522 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ۵ Specify: 3K Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Psychiatric Nurse Health Care 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be (John Henry Robey Elsie Lavetta Conrad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret L. Johnson / daughter 663 Pine Ridge Road, Bedford, PA 15522 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of himportant: if its XBurial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Sunset Memorial Park 01/21/2004 Cumberland, MD 21. Signature of F meral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 Uller ale 23a. ert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or a by Physician/Medical Examiner use es the bunel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician end Due to (or as a consequence of): ō Part I. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 __ Yas BELINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2€ No this After thi 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

within 24 hours efter death.

To the Funeral Director: A completely filled in by the ft edicai 5

MLS State

31. Dete filed (Month, Day, Yeer) Registrar

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature end title of certifie

lin

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Α. M.D., 517 Oldtown Road, Cumberland, MD 21502 Vimala Ranjithan,

JAN 2 0 2004

32. Registrar's Signature

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rav 6/95

Moontz, Alice Virginia

			Please 1	-	nt in Black In			-		egible.	
			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I <i>rtificate of</i>		Mental Hy	/giene Reg. No. (2004	0269
I	Physici /Medi		Decedent's Name (First, Middle, Last Alice Virginia	Koontz				2. Date of De Month	Дау	2 004	3. Time of Death
100	Examir Funeral Director	ner	214-30-2013	Hospital	e (In yrs. last birthday) 90 Yrs.			Nn 8. Date of Bi		Cou	lace (State or Foreign
	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					0d. Inside City Limits
	h the Man r 28e-f sh	Funeral Director	Maryland Washin 10e. Street and Number	gton	Shar	psburg 10f. Zip Code			10g. Citizer	n of What Cou	1 ☐ Yes 2/€No
	23a o	ralD	204 West Chapline	St.		2	1782			USA	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f ahow ha Medical Exama er ituni be notified at	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3√CXWidowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates:	No	Was Decedent of Hill Yes, specify Cub 1 ☐ Yes XXNo		Specify Yes or No to Rican, etc.)		Race - Americ Black, White, pecify:	etc.
2-00	72 hounature	eted	15. Decedent's Edu (Specify only highest grad	cation		dent's Usual Occup		deina	16b. Kind	of Business/In	Vhite dustry
Maryland 21215-0036	led within ygiene. ner than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) /ife.	DO NOT use retire	esser				anufacturer
and	d be fill antal H cod ott	To Be	17. Father's Name (First, Middle, Last) William Clyde	· · · · · ·				me (First, Middle		,	
ary	and Me	F	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street	Manet and Number or R	ta Gay ural Route Numb	Seam	ON own, State, Zip	Code)
	t and 2 tealth om 27 i		Donald Koontz - Sc 20a. Method of Disposition	on	1002 20b. Place of Dispo	Kennon C	Court Ro	ckville,)8 <u>5</u> 1
altimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23s or 28e-1 show any injury or other treumstic event, the Mudical Exams at must be notified at once.		1 Degrated to Disposition 1 Degrated a Communication 3 F 1 Donation 5 Other (Specify) 21. Signature of Euneral Service Communications	LA	Mt. View	natory or other pla	Jan.	21,2004	Sharp	ion - City or To sburg , M	
68760,	Physician /Medical Examiner per unial-transit	dical Examiner	23a. Part1. Epfer the disease, or compleshook or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequential, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	I the death. Do not ent	25 S. Cor	ng, such as cardia	ue St.Wi	rrest,	sport.M	Approximate Interval Between Onset and Death
О. Вох	death certii e attanding d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy	4		23d.	Date of delive Month	ry Day Year
rds, P	The law requires that the tee bas been signed by the bage 2 should be detache		Part II. Other significant conditions con Chronic Obstruct	we hun	9 Diseas		ren in Part I.		obacco use	/	e cause of death?
Vital Records,		Completed by	Congestive Hear	+ Fail	ure					prior to cor death?	osy findings available inpletion of cause of
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		oth	i.L.	ith (Check only o			
Division of	To the Hospitel or Attending Physician: while 24 hours after death of the Funerel Director: Atter this certific completely filled in by the funeral director.	tlon: To	1 Yes 2 No 27. Manner of Death 1 Datural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	ry 28b. Time of	28c. Injur Wor	4 Nursing F	ome 5 Resid)
DIVIS	spitel or Attendi ours after death. erel Director: A filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and No wn, State)	umber or Rura	Route Number,
	To the Hospitel within 24 hours and to the Funerel completely filled	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of the control of	of my knowledge, death examination and/or invited.	occurred at the tir restigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	I manner as sta ce, and due to	ated. the cause(s)
	To the complet	≥	29b. Signature and title of certifier	the So	indo, mp	29c. Licens	e number '451	7	29d. Date sig	gned (Month, L	200 ¥
1	*		30. Name and address of person who co Cynthia Kuther Sa 31. Date filed (Month, Day, Year) JAN 202	npleted cause of d	eath (Item 23a) (Type, W; I RMSP	Print) Nuts	ing Home	, 154 No	anspo	rt Ma	n Street
	Sta Registr	te ar	31. Date filed (Month, Day, Year) JAN 20 2	32. Registra	tr's Signature	pede					

			i lease	Otata at Ma					•		.cgibic.	•	
			For State	State of Ma	•		nt of Health a te of Death				200	1. 00	600
			Registrar	al .		Cermica	e oi Deaiii		Re 2. Date of Deat	g. No.	200	3. Time of	Death
	Physicia	an	Decedent's Name (First, Middle, Las						Month	Day	Year		
40	/Medic	al	Idel1a		irginia		Lewis		anuary			6:35	A
	Examin	er	4a. Facility Name (If not institution, give				Town, or Location of	of Death			county of De		
	F. 3		Memorial Hospital	& Medical	Center	Cumb	erland	24 Hrs o	. Date of Birth	A1	legany	rthplace (State or	r Formian
	Funeral		5. Social Securify Number 6. S	□M 2XCXF	(In yrs. last birtl	rs. Months		Min.	(Month, Day,			Country)	roreign
100	Director	7.	216 - 22 - 6669 Usuel Residence of Decedent	8	2				09/22/1	1921	Ma	ryland	
	land		10a. State 10b. County		10c. City, Town	or Location						10d. Inside Cit	y Limits
	Mary	ō	MD Allega	nv	Cu	mberlar	d					1 🗌 Yes	2 X No
	288 In	Je.	10e. Street and Number	11 y	Ju		Code		10	g. Citiz	en of What (Country?	
	3a o	Funeral Director	11625 Oak Tree F	idge Road			21502			US	A		
	deatl ms 2	Jer	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dece	dent of Hispanic Ori cify Cuban, Mexican	igin? (Speci	fy Yes or No-	1		nerican Indian,	
٥	after or its		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give)		2 No Specify:		Can, 610.)		Black, Wh	inte, etc.	
3	ral', c	by	3 Nidowed 4 Divorced	Year or Dates:		10 163	ZIA NO Specily.				Specify:	White	
ည်	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decedent's Usi (Give kind of w	ial Occupation ork done during mos ise retired)	st of working	,	16b. Kin	d of Busines	s/Industry	
7	or New	upi	Elementary/Secondary (0-12)	College (1-4or 5+)								
2	filed within 72 hours after death with the Maryland Hygiene. Hygiene. the "hat "natural", or items 23a or 28a-f ahow sher than "natural", or items 23a or 28a-f ahow ent, the Medical Examination must be rediffied at	ပိ	11 17. Father's Name (First, Middle, Last)			Homemak		er's Name /	First, Middle, N		Homema	aker	
בב	0 = 5	Be		0 1	т.					1210617			
<u> </u>	should be filed within 72 hours after death with the Marylan and Merial Hygiene. a marked other than "natural", or items 23a or 28a-1 ahow umatic event, the Medical Examinat must be restitived at	ဥ	Adam Clark	Smith,		Mailian Addres	Mar s (Street and Numbe		rginia	City	Twigg		
Maryland 21215-0036	C/ C0 00 00		19a. Informant's Name/Relationship (•				•		,	04 5 0 0
	1 and Health em 27 ther to		Janet L. Wotring 20a. Method of Disposition	<u>/_daughter</u>	20b. Place of	10410 b Disposition (Na v, crematory or	urton Par	CK Dri				or Town, State	21532
وّ	Pages nent of int: If it iry or o		1 X Burial 2 ☐ Cremation 3 ☐					01/01					
	rtmer rtant rtant		 4 □ Donation 5 □ Other (Specify 21. Signature of Fuheral Service Licer 		Restia		Gardens nd Address of Facilit	Community Commun					TD /
Baltimore,	permit. Departr Importa any inja		21. Signature of Futteral Service Licer		ノ	1,000,000,000	Decatur			_		The state of the s	
	402 * 4		23a. Part1. Enter the disease, or com	Allerent caused to	he death. Do n						anu, r	1	
			shock, or heart failure. List only	one cause on each line).	or ontor the the	do or dying, saon as	our diag or	rospiratory arre	, J. J. C.		Approximate Interval Betv Onset and D	veen)eath
	Physician /Medical	89	Immediate Cause (Final disease or condition resulting in death)	a. Aspirati			· · · · · · · · · · · · · · · · · · ·					≮12 hou	rs
	Examiner		1	Due to (or as a	consequence o	if):							
		1	Sequentially list conditions,	b. Due to for as a	consequence of	fi:							
	ted nsit	nln	Sequentially list conditions, the second sec										
	al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of	if):						1	
200	ite be executed ysician and ne burial-transit	cal		d									
687	ficate p phys is the	odlo		. 0.									
Вох	eath certificate attending phy I for use as the	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23	3d. Date of d	elivery	
m	death a atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 □Ectopic 5 □ Other (s					Month	Day Y	'ear
0	s that the de ned by the a e detached f	hys	9 🗆 Unknown	9□ Unknown									
Division of Vital Records, P.O.	Attending Physicien: The law requires that the death certifical coad. • coad. • coad. • to death. • coad the this certificate has been signed by the attending phy the funeral director. page 2 should be detached for use as the coad.	by Physician/Medi	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying	cause given in Part I	l.	23e. Did tob	acco us	e contribute	to the cause of de	eath?
5	quires in signe								1 ☐ Ye	s 2 🗆]No 3□1	Probably 4 📈	nknown
ပ္ပ	tw requir s been si should	Completed							24a. Was a		24b. Were	autopsy findings a	available
æ	The la	E O							autops perform	ned?	death?		Iuse or
ā	an: tiflica tor. p	Bec	25. Was case referred to medical				26. Place	e of Death (Check only one				
\geq	ysici is cer direc	10 B	examiner? 1 Yes 25 No	Hospital: 1 Inpatier	t 2 ER/Out	patient 3 🗍 D	OA Other: 4 □ Nu	ursing Home	e 5 ☐ Reside	nce 6	□Other (Sp	pecify)	
0	g Ph	<u> </u>	27. Manner of Death	28a. Date of Injury (Month, Day	(28b. T	ime of	28c. Injury at Work?	28	ld. Describe ho	w injury	occurred		
<u>ō</u>	ath. r: Aff	atlo	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	1		М	1 ☐ Yes 2 ☐	No					
<u> </u>	ar de	iffic	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At home, far (Specify)	m, street, facto	ry, office	28	If. Location (Sti City or Town	reet and State)	Number or i	Rural Route Numi	ber,
۵	tal or	Certification:											
	Hospital 24 hours a Funeral C	cai	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exar	ysician: To the best oniner: On the basis of	f my knowledge examination and	death occurre	d at the time, date an	nd place, an	d due to the ca	use(s) a	and manner	as stated.)
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	one)	and manner stat	ed.								
	Neith Con	2	29b. Signature and title of certifier	-M/			lc. License number		29	ed. Date	•	nth, Dey, Year)	
	2			410			23371		Ja	anua	ry l	8 2004	
	mes		30. Name and address of person who				25 Kent A						
			Dr. Qamar Zaman,	Johnson H	eights	Medical	Building	, Cum	berland	, MI	215	02	
	Sta Registi		31. Date filed (Month, Day, Year)	2. Hegistra	r's Signature	1							

		1 - For State Registrar	State of Maryl		artment of H tificate of L		Re	g. No. 2	04	02699
Physicia * /Medic Examin	al	Decedent's Name (First, Middle, La: Stephen Brandt Aa. Facility Name (If not institution, give	Lins		4b. City, Town, or	Location of Dea	2. Date of Death Month January	Day	Year 004	3. Time of Death 2:42 P. M
Funeral Director	er	6349 Browns Qua 5. Social Security Number 6. S	rry Rd.	yrs. last birthday) Yrs.		lasville If Under 24 Hrs Hours Min	8. Date of Birth	Fre	ederic	k e (State or Foreign and
Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Md. Frederic	1	. City, Town or Lo		asville			10d.	Inside City Limits
th with the 23a or 28a	ai Director	10e. Street and Number 6349 Browns Quar	ry Rd.		10f. Zip Code	21780	10	0g. Citizen of W		?
s 1 and 2 should be filed within 72 hours after death with the Maryland fleath and Mental Hygiene. The fleath and Mental Hygiene is the fleath and Mental Hygiene is the fleath and Mental Hygiene is the fleath and fleath of the	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 □ No lf Yes, Give Year or Dates: 43	i	Was Decedent of Hi Yes, specify Cuba □ Yes 2 X No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)		American k, White, etc.	
within 72 ho piene. r than *natur it e Medical	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+) 2	(Give	lent's Usual Occupa kind of work done d DO NOT use retired, Lectricial	luring most of wo)	orking	6b. Kind of Bu		•
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnes.	To Be C	17. Father's Name (First, Middle, Last) William Frederi	ck Lins Sr.	10, 14, 7,		Naomi	me (First, Middle, M Livingsto	n		
t and 2 st tealth and om 27 is n ther traun		19a. Informant's Name/Relationship (Louise Lins (V 20a. Method of Disposition	Nife)		Browns		ural Route Number, Rd. Sabill Date 2	asville.	e,Md.	21780
trent of Hrant: If ite		1 ☐ Burial 2 【XCremation 3 ☐ Unnation 5 ☐ Other (Specification 5 ☐ Other (Specification 2)	Removal from State	cernetery, cren Smithsbur	rg Cremate	ory	2004		sburg,	
Permi Impoara		2. Signature of Funeral Service Licer 23a. art 1. Enter the disease, or com	· revi	O Da	Name and Addres	ral Home	OHIT CHOP	rg,Md.	21783	proximate
	edicai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a con b. Due to (or as a con c. Due to (or as a con d.	sequence of):	en					erval Between
at the death certific by the attending p tached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery oth Day	y Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in the un	iderlying cause give	n in Part I.		-		ause of death?
i: The law requireate has been rage 2 should.	Completed						24a. Was an autopsy perform	ed? d		findings available ation of cause of No
. pr 9 6	Certification; To Be	25. Was case referred to medical examiner? 1 Yes	28a. Date of Injury (Month, Day Year		28c. Injury Work M 1 Y	r: 4 □ Nursing I	ath (Check only one dome 5 Resider 28d. Describe how	nce 6 Othe	ed .	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	<u>a</u>	4 Homicide determined	building, etc. (Sp	ecify)	occurred at the tim	e, date and plac	28f. Location (Stre City or Town,	State)	nor as statos	d
To the Hospital within 24 hours a within 24 hours a To the Funeral completely filled	Medica	(Check only one) 2 Medical Examone) 29b. Signature and title of certifier	niner: On the basis of exame and manner stated.	nination and/or inv	estigation, in my op	inion, death occ	urred at the time, da	d. Date signed	nd due to the	cause(s)
Ol ^X Sta	to	30. Name and address of person who with a street of the st	completed cause of death (PA		-				
Registra		JAN 152	UU4 Breeze	D. An	coper					

The Description of Description (Post Adda), (ast) Dorige China (Post A				. For	State of Mar				-	_	01 0070	~
Physician Middled Dor's Brita Lowenhaupt Active year of our cubancy gas series and monotony Active year of our cubancy gas series and monotony Active year of our cubancy gas series and monotony Basilitation Country						Ce	rtificate of I	Death	Re	ig. No. 💪 🖯	U4 UZ/U	U
State Security for control control of health Security (County Transport Security of Death Security (County Transport Security (County Transport Security Transport Security (County Transport Security Transport Security (County Transport Security Transport Secur			- Ar .						Month	Day	Year Tage	M
South Section Section				4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County o		
10 11 20. 10 County 10. Count				958 A St.Clair St	reet		Hagersto	own,		,	-	
10 11 20. 10 County 10. Count		Funeral					If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year)	Birthplace (Stete or Foreig Country)	רון
Time State 10c. County 10c. Treated Columnia 1	Ε	Director		104-16-2060	JW ZŪĄF	81 Yrs.			Jan. 3,			
State Stat	and	1				IOc. City, Town or Lo	ocation				10d. Inside City Limits	s
The Price Name of St. Barnel Charles Cha	Mary	a b	ō	Maryland Washingt	on	Hagersto	מזאו				M☐Yes 2☐No	0
The Price Name of St. Barnel Charles Cha	the the	288	rect			THE GET DEC			10	Og. Citizen of Wi	hat Country?	_
The Price Name of St. Barnel Charles Cha	with	3e or		958 A St. Clair 9	Street		21742	2		II.S A		
State Stat	death	38 2	era		12. Was Decedent Ev	er in U.S. 13.			city Yes or No-	14. Race		
College (1-do 5-) Homemaker Personal Residence Personal Residenc	ē	5 8		1 ☐ Never Married 2 Married	1 ☐ Yes 2 No				Hican, etc.)			
College (1-do 5-) Homemaker Personal Residence Personal Residenc	Sours	Fre Fre		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					Specify:	witte	
College (1-do 5-) Homemaker Personal Residence Personal Residenc	72 h	natu.	etec			16a. Dece (Give	dent's Usual Occup	ation during most of working	ng	16b. Kind of Bus	siness/Industry	
19. Model's value (Press, Model) 19. Model's value (Press, Model) 19. Model's value (Press, Model) 19. Model's value (Press, Model) 19. Model's value (Press, Model) 19. Model's value (Press, Model) 19. Model's value (Press, Model) 19. Model's value (Press, Model) 19. Model's value (Press, Model) 19. Model's value (Press, Model's value) 19. Model's value (Press, M	iffi	P P P	Пфш		College (1-4or 5+))))		Douge aug 1	l Danida	
Charles Henry Moore 13e. International Teachers of Control of Properties of Control of C	ied A	ther t				TION	CHAREL	18. Mother's Name				_
1331 Eastern Blvd. N. Hagerstown, Maryland 23a Part. Enter the dightase, or complications this equivalent to make a shock or heart failine. Little or hone of the shock or heart failine. Little		ed o	8		ore						,	
1331 Eastern Blvd. N. Hagerstown, Maryland 23a Part. Enter the dightase, or complications this equivalent to make a shock or heart failine. Little or hone of the shock or heart failine. Little	P M	natk matk	ĭ	-		19b. Maili	na Address (Street				State. Zip Code)	-
1331 Eastern Blvd. N. Hagerstown, Maryland 23a Part. Enter the dightase, or complications this equivalent to make a shock or heart failine. Little or hone of the shock or heart failine. Little	3 2 5 1 1 2 5 1	lth ar 27 is rtrau					•			•		
1331 Eastern Blvd. N. Hagerstown, Maryland 23a Part. Enter the dightase, or complications this equivalent to make a shock or heart failine. Little or hone of the shock or heart failine. Little	<u> </u>	Iten othe	12	20a. Method of Disposition	_		osition (Name of	D				
1331 Eastern Blvd. N. Hagerstown, Maryland 23a Part. Enter the dightase, or complications this equivalent to make a shock or heart failine. Little or hone of the shock or heart failine. Little	age.	ent of							13,04 I	Flinstor	ne, Maryland	
23a. Part. Enter the dightes, or conditional remainder cause (final List only one class on the land the land of daying, such as cardiac or respiratory ariest. Physician / Medical Cause (Final List only one class on the land of daying and the land of land o		oortar injur	h									
Due to (or as a consequence of): Sequential is conditions at any part of the conditions of the cond	n ā	E : a		1 Jarula	tim							
Due to (or as a consequence of): Sequential is conditions at any part of the conditions of the cond	1	1		23a. Part1. Enter the disease, or comp	lications the sed the						Approximate Interval Between	
Due to (or as a consequence of): Due to (or as a consequence of):	Ph	vsician		Immediate Cause (Final	Ž.,	ma					Onset and Death	i c-
Due to (or as a consequence of): The proposed of the propos	//	Medical			a. Due to (or as a	cons uu of):						L>
The state of the s	Ex	aminer		Sequentially list conditions	b						====	
The state of the s	D	7.70	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):		*				
The part of the pa	ecute	and -tran	каш	that initiated events	c. Due to (or as a	consequence of):						
Female 23c.	Š Š	ician burial			Due 10 (0/ 23 2	consequence or,						
9 Unknown 1 Ves 2 No 3 Probably 4 Unknown 1 Ves 2 No 3 Probably 4 Unknown	Cate	phys s the	O		d							
9 Unknown 1 Ves 2 No 3 Probably 4 Unknown 1 Ves 2 No 3 Probably 4 Unknown	Certif	oding Ise at	/We		23c. If yes, outcome of	pregnancy				23d. Date	of delivery	
9 Unknown 24a. Was an autopsy findings available prior to complete of clause of death? 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 1 Expourable of clause of death? 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 1 Expourable of death? 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings available prior to complete of death? 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 1 Yes 2 No 3 Probably 4 Unknown 25. Was case referred to medical 26. Place of Death (Check only one) 27. Manner of Death (Check only one) 28. Place of Injury 29. Accident 4 Nursing Home 5 Seidence 6 Other (Specify) 29. Accident 5 Seidence 6 Other (Specify) 29. Signature 1 Seidence 1 Seidence 1 Seidence 1 Seidence 1 Seidence 1 Seidence 1 Seidence 1 Seidence 1 Seidence 1 Seidence 1 Seidenc	eath u	atter for u	clar	in the past 12 menths?							· ·	
The state of the s		y the ached	hys	9 Unknown	9□ Unknown							
State	F that	ned b		Part II. Other significant conditions co	ontributing to death but	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contrib	bute to the cause of death?	
State		an sig							1 X Ye	s 2 🗆 No 3	3 ☐ Probably 4 ☐Unknown	n
State	S × S	s bee 2 sho	plet							24b. W	ere autopsy findings available	0
1 Yes 2 No 1 Injury 28c. Injury	The T	te ha	E						perform	gegr/ de	eath?	
1 Yes 2 No 1 Injury 28c. Injury		ortifica ctor. p	0					26. Place of Death				_
State Stat	00		0		Hospital: 1 Inpatient	2 ER/Outpatie	III 3 DOA	4 Nursing Hor	ne 5 eside	nce 6 □Other	r (Specify)	
29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29b. Signatur and title of certiflier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature			i.i		28a. Date of Injury (Month, Day				28d. Describe ho	w injury occurre	d	
29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29b. Signatur and title of certiflier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sion	eath. tor: A the fu	catl	2 Accident investigation					201 1			
29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29b. Signatur and title of certiflier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	or At	oliter d	E	data-minad	286. Place of Injul	y - At home, farm, st (Specify)	reet, factory, office	4	City or Town	reet and Number , State)	r or Hural Houte Number,	
30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) + that Hamman MD 1130 OPAL CT. Hagerstown MD 2174 (State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	pital	ours a		29a Certifier 12 Certifying Phy	/sician: To the heet of	my knowledne deat	h occurred at the tin	ne date and place a	and due to the co	use(s) and man	ner as stated	-
30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) + that Hamman MD 1130 OPAL CT. Hagerstown MD 2174 (State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	e Hos	24 hc Fun etely	dica	(Check only 2 Medical Exam	iner: On the basis of e	xamination and/or in						
30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) + that Hamman MD 1130 OPAL CT. Hagerstown MD 2174 (State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ro th	To the	Me	29b. Signatur and title of certifier	1		29c. Licens	e number	29	d. Date signed	(Month, Day, Year)	monator
State 31. Date filed (Month, Day, Year) 32. Aggistrar's Signature		2 - 0		MINUT	1	IM . ME	17	4647	3	Janu	1914 12. 200) :
State 14 A CONTAIN	x'	Y		30. Name and address of pers in who co	completed cause of dea	ath (Item 23a) (Type,	Print)		11	1	1 10 500	572
State 14 A CONTAIN	<i>b</i> (,			tlind Hama	Lan M); 113	0 01A	L CT.	Hage	utowr	1, MD 2174	tC
	1			31. Date filed (Month, Day, Year)	32. Registrar	's Signature	certas	/	J		A. 245.	

			1 - For State Registrar	State of M	aryland	-	artment rtificate			Ť	giene Reg. No. 2 (006	02	701
Т			Decedent's Name (First, Middle, La	st)						2. Date of De		Year	3. Time o	of Death
	Physici /Medic		Lillian	1. La	Ru	e				Januar		2004	4:33	аМ
	Examin		4a. Facility Name (If not institution, giv				4b. City, T		ation of Death		4c. Coun	ty of Death		
			Residence: 345 Br				If Under 1		yville Inder 24 Hrs.	O Data of Bir	1	Ceci		
п	Funeral Director		5. Social Security Number 6. S 220–24–4808	ΘX □ M 2፟ΔF /. A	ge <i>(In yr</i> s. <i>Ia</i> 84	sτ οιπησαγ) Yrs.			ours Min.	(Month, Da	iy, _{Year)} 13,1919		place (State intry) INSY1va	
			Usual Residence of Decedent							Jan.	13,1717	1 611	IIISYIV	anta
	ryland how	,	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside C	
	Se-fs	cto	Maryland Cec	i1				Perr	yville					2 □ No
	vith th	Dire	10e. Street and Number				10f. Zip (0.0		10g. Citizen of		•	
	s 23e	sral	345 Broad Street	, Apt. 6	Ever in II S	12.1	Mas Decede	219		ecify Ves or No		U.S.A	ican Indian,	<u> </u>
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at 900s.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	? No		f Yes, specification of the second of the se		exican, Puerto	ecify Yes or No Rican, etc.)	Spec	ack, White,		
21215-0036	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual	Occupation	a most of work	ring	16b. Kind of	Business/Ir	ndustry	
215	thin 7 B. "m	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)				g most of work					
2	ed wi	Cou	Seven Years			Dome	estic Er		/Houseke		Domestic		yee/Hous	sekeepe:
Maryland	be fill	Be	17. Father's Name (First, Middle, Last)	y Milburn				18.		e <i>(First, Middle,</i> stine S:			1	
2	hould d Mer narke natic	ဥ	19a. Informant's Name/Relationship (10b Mailie	a Address	Street and A		al Route Number				
Ma	d 2 s th an t7 is r traur		Earl W. LaRue, J							Deposit				ı
	tem 2		20a. Method of Disposition	(10011)	20b. Pla	ce of Dispo	sition (Name	of of		Date	20c. Location			
ê E	Pages ent of nt: If I		1 X Burial 2 ☐ Cremation 3 ☐ 3 4 ☐ Donation 5 ☐ Other (Special		9		Cemet		01/	15/04	Darlin	gton,	Mary1	Land
Baltimore,	permit. Departm Imports any inju		21. Signature of Funeral Service Lice	1500	L	Name and	Patte	rson &	Son Fur	neral H	ome,	P.A.		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death.	Do not ent	er the mode	of dying, su	ch as cardiac	nd 2190 or respiratory a	73-0766 rrest,		Approxima Interval Be	ite
1	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	tas-	tation of):	c 11	ver	canc	er			Onset and	
Q =	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseque	ence of):								
,	acute ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	ate be executed hysician and the burial-transit	Ē	resulting in dealing cust	Due to (or as	s a conseque	ence or):								
87	physi the b	dlcal		d										
.O. Box 6	res that the death certifica igned by the attending pl be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3]Ectopic pre] Other (s <i>pe</i>				1	ate of deliv fonth	•	Year
<u>α</u>	The law requires that the ate has been signed by the bage 2 should be detache	ed by Pr	Part II. Other significant conditions of	contributing to death	but not resul	ting in the u	nderlying ca	use given in	Part I.		obacco use cor Yes 2 🗆 No	ntribute to t		death? Unknown
Division of Vital Records,	The law requir cate has been si page 2 should I	Completed								24a. Was autor perfo 1 \(\text{Yes} \)		Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings ompletion of a	available cause of
/ita	Phyaician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?						Place of Deat	h (Check only o	one)			
<u>\$</u>	Physic this c	7°	1 Yes 2 No	Hospital: 1 ☐ Inpat		R/Outpatier 28b. Time of			☐ Nursing Ho	me 5 Resid			fy)	
n C	ffer ne	llon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inj (Month, D	ay Year)	Injury	M 20	c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe I	now injury occu	med		
Divisio	or Attanding after death. Diractor: Afte in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined		njury - At hon atc. <i>(Specify)</i>	ne, farm, str				28f. Location (: City or Tox		ber or Rur	al Route Nur	nber,
_	To the Hospital or Attandii within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical Co		nysician: To the bes miner: On the basis and manner s	of examination									s)
	To the within To the compl	Me	29b. Signature and title of certifier	2	l a	^		License nun			29d. Date sign			×04
	2		30. Name and address of person who	. /		23a) (Type,				Rd				
	Sta	to	31. Date filed (Month, Day, Year)	M 32. Regist	trar's Signati	ıre Ce	is W	· Mc	-nail	KOL!		, , , ,	ID H	014
	Regist		JAN 1 5 2004	Harry 1	y do	antis								
Dh	MH 17 Rev 1/2	001	- 0		a mere									

Lillian V. Larue

		1	For State Registrar	State of	Maryla		artment of H			jiene eg. No. 200	4 02702
			I. Decedent's Name (First, Middle, Last,						2. Date of Dea Month	th Day Year	3. Time of Death
	sicia ledica	al		ewis					January	16 2004	7 7 7 7 7
Exa	mine	er 4	a. Facility Name (If not institution, give		nber)			Location of Death	1	4c. County of Dea	
Fune	ral		6750 Simmons Lar 5. Social Security Number 6. Sec	()	7. Age (In yrs	. last birthday)	Clint If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Prince (9. Bir	George 's thplace (State or Foreign ountry)
Direc			228-42-4870 Jsual Residence of Decedent	™ ¾	68	Yrs.	Months Days	Hours Min.	(Month, Day	30,1934 Vi	
and		-	Jsual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation		-1		10d. Inside City Limits
Maryli f sho		.	Maryland Prince G	eorge's		Clinton	1				1 Tes 2 No
h the		<u>-ec</u>	10e. Street and Number				10f. Žip Code		1	0g. Citizen of What Co	ountry?
th wit	181	<u>a</u>	6750 Simmons Lar	ne			2073	5		U.S.A.	
Iltimore, Maryland 21215-0036 nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental Hygiene. The control of Health and Mental Hygiene. The control of Health and Mental Hygiene.		by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	ces? XXNo e	i	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi Specify: W	
21215-0036 sq within 72 hours aff rgiene. griene "natural", or er than "natural", or			15. Decedent's Edu	cation		16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	/Industry
1215 within 73 ene. than "na	MEG	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1	-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of won			
d 21 filed will Hygien other th	M .	Sol	12th			Dog	Groomer	40 Marka da Nasa		Self-emplo	yed
Maryland 1d 2 should be file lith and Mental Hy 27 is marked oth	evan	To Be	17. Father's Name (First, Middle, Last) George And	derson				Viola		Maiden Sumame) ynolds	
should wen warke	i metr	۲	19a. Informant's Name/Relationship (T)	rpe, Print)				and Number or Ru	ral Route Number	, City or Town, State, .	
and 2	er tra		Linda S. Bradsha	v (Daug	hter)	675) Simmons	Lane Cl:	inton, M	aryland 20	735
Baltimore, bermit. Pages 1 ar Department of Hea Important: If term:	E C		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F	Removal from S		Place of Dispo cemetery, crea	sition (Name of matory or other plac		17,	20c. Location - City or	Town, State
timor trant of trant: If it	, de la la la la la la la la la la la la la		*4 ☐ Donation 5 ☐ Other (Specify)			ee Cre	natory	2004		Clinton,	
Baltimol permit. Pages Department of Important: If i	any ir		21. Signature of Funeral Service Licens	H	******		2. Name and Addres	JLIK.		al Home, I	
		+	23a. Part1. Enter the disease, or compl	ications that co	M011 aused the dea						Approximate Interval Between
Physic	iau		shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on e	Kes	L at		Laulu	~		Onset and Death
/Medi	cal		resulting in death)	a Due to (or as a conse						
Examir			Sequentially list conditions,	b	9.	phice	earl v				
P) Sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or knur)	Due to (or as a cons	quence of):	Ca	m ces	_		
axecut	al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	equence of):				· · · · · · · · · · · · · · · · · · ·	
68760, ficate be executed physician and	nng e	ledical E	· ·	d							
rtificat	as th	Medi	IF FEMALE:								
Box 61 death certific e attending p	or use	Physiclan/M	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fei	tal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
. 0 0	ched t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9⊟Unkno	ant at time of own	death 5L	Other (specify)				
- E P	0		Part II. Other significant conditions co	ntributing to de	ath but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
rds, quires		ed by							1 □ Y	es 2⊡No 3⊡P	robably 4 🛣 Inknown
Recor	2 sho	Completed							24a. Was a	sv prior to	utopsy findings available completion of cause of
The The	page	Con							perfor 1 ☐ Yes		2 □ No
of Vital Physicien:	octor	Be	25. Was case referred to medical examiner?	Hospital:			oth Oth	or	th (Chack only or		-
Of Phys	<u></u>	2	1 ☐ Yes 2 💆 No 27. Manner of Death	28a, Date	of Injury	ER/Outpatie	1 3 DOX	4 🗀 Hulaling II		ence 6 Other (Spe ow injury occurred	ecify)
VISION OF Attending Pher death.	e tune	tlor.	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mont	h, Day Year)	Injury	Wor M 1 □	k? Yes 2 ⊡No			
Division of Vital Records, lor Attending Physicien: The law requires a after death. Director: After this certificate has been sign.	by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildi	of Injury - At	home, farm, st	reet, factory, office		28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,
Hospital of the hours of Funeral D	pell		29a. Certifier Certifying Phy	elcien: To the	host of my kr	cowledge deat	h occurred at the fir	no, data and place	and due to the c	ause(s) and manner a	e etatod
e Hospital 24 hours a	completely filled in by	edical		ner: On the ba	asis of examir ner stated.	nation and/or in	vestigation, in my o	pinion, death occu	rred at the time, o	late and place, and du	e to the cause(s)
To the Ho within 24 To the Fu	comp	Me	29b. Signature and title of certifier	0 2			29c. Licens			9d. Date signed (Moni	th. Day, Year)
						My	DO	04792	-7	1/18/04	
084				okoh	my	эт 23a) (Туре,	0121711	19 RD. V	UF #30	4 was	t-DC
Re	Stat gistra		31. Date filed (Month, Day, Year) JAN 2 1 2	2004 32. R	gistrar's Sign	nature	Se 1010 11				

			1 - For State Registrar	State of M	Marylan		artment of I		Mental Hyg	iene g. No.200	4 02	703
			Decedent's Name (First, Middle	e, Last)					2. Date of Deat	h		ne of Death
	Physici /Medi		Arline	Frances	Mi	ddletor	1		Month		ear 19:	05 M
	Examir		4a. Facility Name (If not institution	n, give street and numbe	97)		4b. City, Town, o	or Location of De	ath	4c. County of	Death	
			Socred Hear				Cum	perland	<u>. </u>	Alle	BANY	
	Funeral Director		5. Social Security Number 214-30-9678		Age (<i>In yr</i> s. 1 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		1919	Birthplace (Sta Country)	ate or Foreign
			Usual Residence of Decedent		04				Jul 14,	1313	IVID	
	ylanc		10a. State 10b. County Allec		10c. Cit	y, Town or Lo					10d. Insid	de City Limits
	e Ma	ctor	MID VIIE	Jany		Frost	July				₩	Yes 2 ☐ No
	or 26	Dire	10e. Street and Number	-4			10f. Zip Code	04500	1	0g. Citizen of Wha	_	
	be filed within 72 hours after death with the Maryland Ital Hygiene. Indocent than "natural", or flems 23a or 28a-1 ahow avant, I'ra Medical Examinar rinal be rotified at	Funeral Director	198 Glenn Stree			0 10		21532	10 11 11	USA		
	ter de	Š	11. Marital Status 1 Never Married 2 Marr	12. Was Deceder Armed Forces	s?	.5.		an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		American India White, etc.	n,
920	urs af		3 ☐ Widowed 4 ☐ Divorced	If Yes Give	s:		1□Yes 2□No	Specify:		Specify:	Vhite	
2-0	72 ho	Completed by	15. Deceden	nt's Education est grade completed)		16a. Dece	tent's Usual Occup	oation	notine	16b. Kind of Busir		
21	within 900.	npie	Elementary/Secondary (0-12)	College (1-4o	or 5+)	l .	kind of work done DO NOT use retire	d)				
12	Hygier Hygier ther th	ဝိ		14)		Lab As	sistant			llegany E	alistics	
ano	d be find the of other	To Be	17. Father's Name (First, Middle, Thomas Willia						ame (First, Middle, A aroline (Ga		helm	
Maryland 21215-0036	should nd Men marke imatic	5				19h Mailir	on Address (Street					
Z	permit. Pages 1 and 2 should Department of Health and Mer mportant: If Itam 27 Is marke any injury or other traumatic MES.		19a. Informant's Name/Relations Albert Middleton	husb	pand	198 (Glenn Str	eet	Rural Route Number, Frostbu	urg	MD 2	1532
re,	S 1 a	1	20a. Method of Disposition			lace of Dispo	sition (Name of natory or other pla	(a)	Date	20c. Location - Cit	y or Town, Stat	е
E	Pages nent of int: If i		1 Burial 2 Cremation 1 Donation 5 Other (S		^{te} Scar	pelli Fur	neral Home	, PA	1/19/2004	Cresapto	wn	MD
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service	Licensee	4	. 22	Name and Address	ss of Facility	tome PA			
<u> </u>	825 5 8		Cames	1 /Dey	elle		108 Virg	inia Avenu	ie: Cumberla	nd, MD 21	502	
žģ.			23a. Part1. Enter the disease, or shock or heart failure. List	complications that cause only one cause on each	ed the death line.	n. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory arre	st,		Between
	Physician		Immediate/Cause (Final disease or condition	-a Pu	Imo	130000	Eml	solisi	$\gamma \gamma$		Onset a	and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):	0.				7.1	
		10	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. ISC	AS a consequ	JIC C	-occodio	1 my	YOULNA		124	fars
	rted	nine	Cause (Disease or Injury	\$ Ch	ray :		beteu	+	Automate	1:00	100	GC(FS
Ć.	te be executed ysicien and ie burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	as a consequ	uence of):	272 16 01	11/16	DU PHOHAF	1 D1754	56	10117
8760,	sate be executed physicien and the burial-transit	cai		d								
9	ntifica ng ph nas th		IF FEMALE:									
Вох	death certifics e attending ph id for use as ti	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			Ectopic pregnancy	,		23d. Date of		Vara
E	the al	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐Unknown		eath 5□	Other (specify)			Month	Day	Year
P.O.	res that the de signed by the a be detached f	by Physician/Med	Part II. Other significant condition	ons contributing to death	hut not resu	dting in the ur	derhing cause an	en in Part I	23a Did tob	acco use contribu	to to the eauce	of doath?
Records,	The law requires that the ste has been signed by the bage 2 should be detache			and some some some some	- Dut 1131 1331	and in the di	idanying cause giv	on mr arti.			Probably 4	
Sor	w requir been si should	iete							24a. Was an			
Re	The law cate has page 2.	Completed							autopsy perform	prior	e autopsy findin r to completion (th?	of cause of
tal	iician: Th certificate rector, pag		25. Was case referred to medical	1				26 Blace of Dr	1 ☐ Yes 2 eath (Check only one	Ø No 1□	Yes 2□ No	
>	Physician: r this certifica ral director, p	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 In a	tient 2	ER/Outpatien	t 3□ DOA Oth	or:	Home 5 Reside		Spacifu)	1
0	g Ph	L.	27. Manner of Death	28a. Date of In	iury	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe hor		specify)	
Ö	Attending ir death. ector: After by the fune	atio	Natural 5 Pendin investig	gation	yay reary	пцигу		Yes 2 □ No				
Division of Vital	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place of Ir	njury - At ho etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number o State)	r Rural Route ^	lumber,
	oital o ris afi rai Di			1					+			
	Hospital or 24 hours afte Funeral Dir tely filled in	edical	29a. Certifier 1 Certifyin (Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	of examinat	wledge, death ion and/or inv	occurred at the tir estigation, in my o	ne, date and place pinion, death occ	ce, and due to the car curred at the time, da	use(s) and manne te and place, and	r as stated. due to the caus	se(s)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Med	29b. Signature and title of certifler	and manner s	stated.	3/	29c. Licens			d. Date signed (M		
)	/			lennawi, n	10	13						
	6		30. Name and address of person			23a) (Type	Print)	~		- Toury	110.4 (4	200.7
	Mas		George Henna	WIND 0		Bisho	p wals	h Redo	J. Cumba	Rand,	MD21	1502
	Sta	te	31. Date filed (Month, Day, Year)	22. Regis	strar's Signat	ture.	/				**************************************	
	Registr	ar	OHIN & O COL	J4 P	. Park	1 1	DOLKS!					

			_ For	i lease i		aryland / De	partment of H	lealth and M		_	00701
			1 - State Registrar			<i>C</i>	ertificate of L	Death		1. No UU4	UZ/U4
п	Physici	an	1. Decedent's Name (F Harry	First, Middle, Last) S.		McClell	on.		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al .				MCCIell		I continue of Dooth	0	3 2004	<u> 2250 ™</u>
	Examin	er	4a. Facility Name (If no	1 1	4 .	101		Location of Death		4c. County of Death	
	F		SACred 5. Social Security Num	MEART ber 6. Sex		e (In yrs. last birthda		RIANCI If Under 24 Hrs.	8. Date of Birth	ALLEG 9. Birth	place State or Foreign
п	Funeral Director		212-32-80	86 1)		S8 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) NOV 29	1935 Con	Wib .
			Usual Residence of De			T				· · · · · · · · · · · · · · · · · · ·	
	anylar show	_	MD 10a. State	Allegany	v	10c. City, Town or LaV					10d. Inside City Limits 1√2 Yes 2 ☐ No
	the Maryland 7 28a-f show	ecto			, 				100	Civir and All Andrews	
	with the or 2	ä	10e. Street and Number 1131 Brad		ad		10f. Zip Code	21502	100	g. Citizen of What Cou USA	intry?
	hours after death with the Maryland tural', or Itams 23a or 28a-f show at Examiner must be notified at	Funeral Director	11. Marital Status		12. Was Decedent	Ever in U.S. 1	3. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Amer	ican Indian,
ပ္	or Itan	Fun	1 Never Married	X 2 Married	Amed Forces? 1X Yes 2 1 1 Yes, Give	No	If Yes, specify Cuba		Rican, etc.)	Black, White	
03	ral', c	d by	3 Widowed 4 [Divorced	If Yes, Give Year or Dates:	1955-58	1 Yes 2 No	Specify:		Specify: Wh	te
5-0	72 h 'natu	Completed	15 (Specify	. Decedent's Edu only highest grade	cation completed)	16a. De	cedent's Usual Occupa ive kind of work done of b. DO NOT use retired	ation during most of worki	ng 16	6b. Kind of Business/I	ndustry
121	within 72 ane. than "nat	mpi	Elementary/Second	ary (0-12)	College (1-4or		s. DO NOT use retired Lubber	"	1	re Co.	
2	D D = -	ပ္ပိ	17. Father's Name (Fir	st, Middle, Last)		171111	adbbo!	18. Mother's Name	(First, Middle, Ma		
an	ad la be	To Be		air McCle	ellan				Humberts		
Maryland 21215-0036	s 1 and 2 should by Health and Menta Health and Menta Item 27 is marked other traumatic e		19a Informant's Name Sylvia McC	Relationship (Ty	wife	19b. Ma 113	ailing Address (Street a	and Number or Rura k Road	l Route Number, C LaVale	City or Town, State, Z	^{p Code)} MD 21502
	f Heal f Heal ftem 2	1	20a. Method of Dispos	ition		20b. Place of Dis	sposition (Name of		Date 20	c. Location - City or 1	own, State
SE SE			1 ☐ Burial 2 ☐ C		lemoval from State	Scarpelli F	rematory or other place uneral Home,	PA 1	/17/2004 (Cresaptown	MD
Baltimore,	permit. Page Department of Important: If any injury or ance.	i	21. Signature of Fune		ee 1	M- 1	22. NanScarpelli	Filightal Ho	me PA		
m	Depa Impo any i		Yliche	Las 4	. Acar	00 De 1				nd, MD 21502	
1			23a. Part1. Enter the shock, or heart fa	disease, or complailure. List only of	ications that cause ne cause on each li	the death. Do not	enter the mode of dying	g, such as cardiac o	or respiratory arres	t.	Approximate Interval Between
	Physician	4	Immediate Cause (Fir disease or condition		ALU	te A	enal 1	Callure	2		Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a consequence of):	11.				
萄	Lamine	_	Sequentially list condi	tions.	. Hout	e Tunu	ar Nec	10565			
	led sit	Examiner	r any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	ng ary	Due to for as	a consequence of).					
	be executed iician and burial-transif	xar	that initiated events resulting in death) Las		Due to (or as	a consequence of):					
760,	0 0	cai			1.						
89	leath certificat attending phy I for use as th			-1-					200		
Вох	th cer endin	N/us	IF FEMALE: 23b. Was decedent pr	egnant	3c. If yes, outcome		3 DEctopic pregnancy			23d. Date of deliv	· ·
	The law requires that the death certifica tte has been signed by the attending phi bage 2 should be detached for use as th	by Physician/Med	in the past 12 mo		4☐Pregnant at 9☐Unknown		5 Other (specify)			Month	Day Year
P.0	at the ded by the etached	Phy	9 Unknown	ne conditions				- is Book	22a Did teha	cco use contribute to	the equal of death?
S,	ires tha signed d be det		Part II. Other significa	101 6	hvallah	Ultra	differing cause give	on mranti.			bably 4 Dunknown
Ö	w requir been si should	etec	Δ,	1011 11		1 -1	1 6/201	<u> </u>			
Vital Records,	elaw hast	Completed	150	ute g	GS+10111	169 MARI	b/RAMI	ins	24a. Was an autopsy oerforme	prior to co	opsy findings available empletion of cause of
a			Die	behes	1941114	5			1 ☐ Yes 2 €		2□ No
	Attending Physician: r death. sctor: After this certific. by the funeral director.	o Be	25. Was case referred examiner? 1 Yes 2 No	1	lospital:	ent 2 ER/Outpat	tient 3 DOA Othe	OF:	(Check only one)	ce 6 ☐Other (Spec	4.)
of	g Phys ter this neral di)- I	27. Manner of Death		28a. Date of Inju (Month, Da		of 28c. Injury	/ at	28d. Describe how		19)
io	nding l ath. r: After e funer	atio	1 ⊠Natural 2 ☐ Accident	5 Pending investigation	(Month, Da	y Year) Injur		Yes 2 □ No			
Division of	r Attendi er death. rector: A by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide	Could not be determined	28e. Place of Inj	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stre	et and Number or Rui State)	al Route Number,
D	ital or rs afte ral Dir led in l							Į.			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2[Certifying Phys	ner: On the basis o	f examination and/or	eath occurred at the time investigation, in my op	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and titl	a of certifier	and manner st	ated.	29c. License	number	290	. Date signed (Month)	Dav. Year)
				/	11/1	Minm		35/3	5	1/14/	24
	8		30. Name and address	of person who co	ompleted cause of c	leath (Item 23a) (Tur	De. Print)	- 3 / 0		11.110	
•	MAS		Thomas	5 8.1	Chene	1/ MI)	9175	Oten D	- Cam.	berlann	mo
16	Sta	_	31. Date filed (Month,	Day, Year)	3. Registr	ar's Signature	1				
	Registr	ar I	JAIN	1 0 / 1114			11/12/11/20				

Amended #22, nls, 1/14/04, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar			iai yiai i		tificate			a Men	tal Hygi	g. No. 20	04	02705
	Physici /Medic		1. Decedent's Name (F BLAINE		ULLOUGH						l h	Date of Death Month NUARY	Day	Year 004	3. Time of Death
	Examir		4a. Facility Name (If no MEMORIAL H		street and number	r)		CUMBE					4c. County		
	Funeral Director		5. Social Security Num 217–10–544	7	X 7. A	nge (In yrs. I	ast birthday) Yrs.	If Under 1 Months		Under 24 h	Ain. (/	Date of Birth Month, Day, T. 29		Coui	place (State or Foreign htry) VIRGINTA
Aarvland	f ehow	or	Usual Residence of De 10a. State 10	ob. County MINERA	\L		, Town or Lo								10d. Inside City Limits
the A	r 28a-1	irect	10e. Street and Number					10f. Zip 0	Code			10	g. Citizen of V	Vhat Cou	ntry?
th wit	23a c	a D	ROUTE 3,	BOX 3	3			20	6753				U.S.	Α	
CIZIO-0000 within 72 hours after death with the Maryland	s 1 and 2 should be lised within 1.2 hours allef death with the maryla if Health and Mental Hygiene. I tem 2.3 a cr 28a-1 e hou tiem 2.7 is marked other than "natural", or items 2.3a or 28a-1 e hou other traumatic event, the Meulical Examinational Candidate.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s?] No		Was Decede f Yes, specif 1 □ Yes 2		nic Origin? Nexican, Pi pecify:	? (Specify uerto Ricar	Yes or No- n, etc.)		k, White,	can Indian, etc. [ITE
20-612	nin /z nou n. n. "natura Medical E	Completed		5. Decedent's Edi only highest grad	ucation		(Give	dent's Usual kind of work DO NOT use	done durir		working	1	6b. Kind of Bu	usiness/In	ndustry
itted with	/giene	Com	12			,	TELE	GRAPI					RAILR		
ar yrallo	Mental Hy Mental Hy arked oth atic event	To Be	17. Father's Name (Fin		JLLOUGH,	SR.				MAR	Y NE	WCOME			
, Mar	l and 2 sno fealth and im 27 Is m har traum		19a. Informant's Name HELEN MO			FE						ute Number. GELEY	City or Town, WV	State, Zip 267	
allimore	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or othar once.		20a. Method of Dispos 1 Durial 2 0 4 Donation 5	Cremation 3 🔲	Removal from State	e Ce	lace of Dispo emetery, cren RT ASHI	natory or oth	ner place)	7 01	Date /17/2		oc. Location -		
	permit. Permit		21. Signature of Fune	ral Service Licens	Too has	10)	22	Name and	Address of	Facility	L HOM	E, P.A	۱.		
	# P		23a. Part1. Enter the shock, or heart f. Immediate Cause (Fir	allure. List only o	one cause on each	line.									Approximate Interval Between Onset and Death
	hysician /Medical Examiner		disease or condition resulting in death)	(Due to (or a	is a consequ	uence of):	c Oo	Stru	ctive	Pul	Morrie	y Disea	se	loyes.
cuted	nd transit	Examiner	Sequentially list condi- if any, leading to immicause. Enter Underly Cause (Disease or inju- that initiated events resulting in death) Las	ediate ing ury	Due to (or a										
OX OO/OU,	sate be executed physicien and the burial-transit	dical Ex	resulting in death) cas		Due to (or a	is a consequ									
OX O	in certific lending p	a a		·	d		dence or):								
O D	ne dea r the att	ysician/Me	IF FEMALE: 23b. Was decedent print the past 12 mt 1 □ Yes 2 □ M 9 □ Unknown	onths?	d	ne of pregna	ncy	Ectopic pre					23d. Dat	te of delive	ery Day Year
T.C. o	ures that the dea signed by the att d be detached fo	by Phys	23b. Was decedent print the past 12 mg 1 Yes 2 N	onths?	d	ne of pregna 2 ∐ Fetal at time of de	incy Ideath 3 eath 5	Other (spe	cify)	n Part I.			Monacco use contr	nth nbute to t	
ords, P.O. D	requires that the been signed by the hould be detache	by Phys	23b. Was decedent print the past 12 mg 1 Yes 2 N 9 Unknown	onths?	d	ne of pregna 2 ∐ Fetal at time of de	incy Ideath 3 eath 5	Other (spe	cify)	n Part I.		1 Z Yes 24a. Was an autopsy perform	Mo acco use conti	nibute to ti 3 Prot	he cause of death? bably 4 Unknown bopsy findings available impletion of cause of
The law requires that the deat	Ine la ate has page 2	e Completed by Phys	23b. Was decedent printle past 12 mt 1 Yes 2 N 9 Unknown Part II. Other significa	ant conditions co	d	ne of pregna 2 ∐ Fetal at time of de	incy Ideath 3 eath 5	Other (spe	use given ir			1 Z Yes 24a. Was an autopsy perform	Modacco use contribution of the second of th	nibute to ti	he cause of death? bably 4 Unknown bopsy findings available impletion of cause of
Ital Records, F.C. D	lan: The la rtificate has tor, page 2	Be Completed by Phys	23b. Was decedent print the past 12 mt 1 Yes 2 N 9 Unknown Part II. Other significa	ant conditions co	d	ne of pregna 2 ∐ Fetal at time of de but not resu	incy Ideath 3 eath 5	Other (spe	use given ir	. Place of	Death (Ch	1 X Yes 24a. Was an autopsy perform 1 Yes 2	Modacco use contribution of the second of th	nibute to the second of the se	he cause of death? bably 4 Unknown opsy findings available impletion of cause of 2 No
Ital Records, F.C. D	lan: The la rtificate has tor, page 2	To Be Completed by Phys	23b. Was decedent printly past 12 mt 1 Yes 2 N 9 Unknown Part II. Other signification 25. Was case referred examiner? 1 Yes 2 N 27. Manner of Death 1 Natural 2 Accident	d to medical 5 Pending investigation	d	but not resu	incy death 3 eath 5 eath 5 eath 5 eath 5 eath 5 eath 5 eath 5 eath 6 eat	Other (spe	use given ir 26 Other: Work?	. Place of	Death (Ch	1 Z Yes 24a. Was an autopsy perform 1 Yes 2 eck only one	Modacco use control 2 □ No 24b. \ 6 3 No 1	nith initial and	he cause of death? bably 4 Unknown opsy findings available impletion of cause of 2 No
Ital Records, F.C. D	lan: The la rtificate has tor, page 2	Be Completed by Phys	23b. Was decedent printly past 12 mt 1 Yes 2 N 9 Unknown Part II. Other signification 25. Was case referred examiner? 1 Yes 2 N 27. Manner of Death 1 N 2 Accident	ant conditions co	d	but not resultient 2	eath 3 = eath 5 = eat	Other (spenderlying call to 3 DOA M	use given in 26 A Other: Uc. Injury at Work? 1 \rightarrow Yes	. Place of 4 □ Nursin	Death (Ching Home 28d.	1 Yes 24a. Was an autopsy perform 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2	Modulation Modulation	nibute to ti 3 Prot Were auto prior to co death? Yes er (Specified	he cause of death? bably 4 Unknown opsy findings available impletion of cause of 2 No
Ital Records, F.C. D	lan: The la rtificate has tor, page 2	edical Certification; To Be Completed by Phys	23b. Was decedent printhe past 12 mt. 1 Yes 2 N 9 Unknown Part II. Other signification 25. Was case referred examiner? 1 Yes 2 N No. 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	d to medical 5 Pending investigation 6 Could not be determined	d	but not resultient 2 ijury ay Year) injury - At hoetc. (Specify st of my know of examinations at the control of examinations of examinations at the control of examinations at the con	ER/Outpatien 28b. Time of Injury ome, farm, str.	other (spe	use given in 26 A Other: 10. Injury at Work? 1 Yes office	i. Place of 4 □ Nursin 2 □ No date and pl	Death (Ch ng Home 28d.	1 ★ Yes 24a. Was an autopsy perform 1 Yes 2 eck only one 5 Resider Describe how cocation (Street, Street, Mo acco use contributions according to the second	nibute to ti 3 Prot Were autorior to co death? Pes er (Specified	he cause of death? bably 4 Unknown posy findings available impletion of cause of 2 No al Route Number,	
Ital Records, F.C. D	lan: The la rtificate has tor, page 2	To Be Completed by Phys	23b. Was decedent printly past 12 mt 1 Yes 2 N 9 Unknown Part II. Other signification 25. Was case referred examiner? 1 Yes 2 N 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	ant conditions co	d	but not resultient 2 ijury ay Year) injury - At hoetc. (Specify st of my know of examinations at the control of examinations of examinations at the control of examinations at the con	ER/Outpatien 28b. Time of Injury ome, farm, str.	other (spenderlying call the strength of the s	use given in 26 A Other: 10. Injury at Work? 1 Yes office	i. Place of 4 □ Nursin 2 □ No date and pl date and pl on, death c	Death (Ch ng Home 28d.	1 Yes 24a. Was an autopsy perform 1 Yes 2! eck only one 5 Resider Describe hov cocation (Street) city or Town, due to the cauthe time, dail	Mo acco use contributions according to the second	nibute to the nibute to the nibute to the nibute to the nibute to the nibute to confort	he cause of death? be bely 4 Unknown begin indings available impletion of cause of 2 No fy) al Route Number, stated. o the cause(s)
Ital Records, F.C. D	Ine la ate has page 2	edical Certification; To Be Completed by Phys	23b. Was decedent print the past 12 mt 1 Yes 2 No 9 Unknown Part II. Other signification 25. Was case referred examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 11 (Check only one)	d to medical 5 Pending investigation 6 Could not be determined Certifying Physical Example of certifier	d	but not resultient 2 njury - At hoetc. (Specify st of my known of examinal stated.	eath 3 = eath 5 = utiling in the unapplication ER/Outpatien 28b. Time of Injury Dome, farm, str. wledge, death tion and/or in	other (spenderlying called the spenderlying called the	use given in 26 A Other: tic. Injury at Work? 1 Yes office	i. Place of 4 □ Nursin 2 □ No date and pl date and pl on, death c	Death (Ch ng Home 28d.	1 Telyes 24a. Was an autopsy perform 1 Yes 2 eck only one 5 Resider Describe how cocation (Street City or Town, due to the cauthe time, dail	Modulated and Number State) Modulated And Number and N	nibute to ti 3 Prot Were autorior to co death? Pyes er (Specified er or Rura anner as s and due to	he cause of death? be bely 4 Unknown begin indings available impletion of cause of 2 No fy) al Route Number, stated. o the cause(s)
Ital Records, F.C. D	To the Hospital or Attending Physician: The lat within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical Certification; To Be Completed by Phys	23b. Was decedent printly past 12 mt 1	ant conditions continues to the medical of the medi	23c. If yes, outcom 1	tient 2 igury - At ho etc. (Specify st of my knor of examinal stated.	ER/Outpatien 28b. Time of Injury whedge, death tion and/or insured the control of	other (spenderlying call the spenderlying ca	use given in 26 A Other: Work? 1 yes office	2 No	Death (Ching Home 28d. Line)	1 Yes 24a. Was an autopsy perform 1 Yes 2! eck only one 5 Resider Describe hov cocation (Street) cocation (Street) due to the cat the time, dat	Mo acco use contribution of the second of	nibute to the ni	he cause of death? he cause of death? pably 4 Unknown posy findings available impletion of cause of 2 No No A Route Number, stated. o the cause(s) Day, Year) 2004

			For State Registrar	te of Mar		artment of F		nd Mental Hy	giene Reg. No.	2004	027	06
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of	
	/Media	al	HERBERT W. MORELAND			4h City Town a	al coation of	JANUARY	_	004 County of Death	3:35	Дм
	Examin	er	4a. Facility Name (If not institution, give street and EDEN PINES ASSISTED LIVI			4b. City, Town, o		Death	40.	WASHING		
	Funeral		5. Social Security Number 6. Sex	7. Age (/	n yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th	9. Birth	place (State o	r Foreign
	Director		232-28-2266 1 [™] 2	□ F 8	8 Yrs.	Months Days	Hours	Hrs. 8. Date of Bir (Month, Da 12/24/1	915	BERKI	ELEY CO.	, WV
	pug *		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or Lo	ocation			-		10d. Inside Ci	tv Limits
	Maryle f sho	ъ	W BERKELEY			RTINSBURG					1 X Yes	•
	r 28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	intry?	
	th with	a D	711 BOWERS STREET			2	25401			USA		
	ams sur	ner	l An	s Decedent Evened Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origi an, Mexican,	n? (Specify Yes or No Puerto Rican, etc.))- 1	4. Race - Amer Black, White		
36	or li	by Funeral Director	1 Never Married 2 Married 1 (15) 3 Widowed 4 Divorced Ye	Yes 2XXNo es, Give ar or Dates:		1 ☐ Yes 2 ☒ No	Specify:			Specify: W	HITE	
21215-0036	2 hour		15. Decedent's Education		16a. Dece	dent's Usual Occup	ation		16b. Kin	id of Business/Ir		
215	hin 72 e an "na Madi	per	(Specify only highest grade comp Elementary/Secondary (0-12) Co	leted) llege (1-4or 5+)	life.	kind of work done DO NOT use retired	during most o d)	of working		RESIDENT:	[AL	
7	filed within 72 hours after death with the Maryland Hyglene. thar than "natural", or Itams 23a or 28a-f show that the Medical Exambra must be indiffed at	Completed	2		CA	RPENTER						
Maryland	e de la Se	Be	17. Father's Name (First, Middle, Last) CHARLES MORELAND					s Name <i>(First, Middl</i> e ABELLE "UN				
Z	2 should and Men Is marke sumatic	2	19a. Informant's Name/Relationship (Type, Pr.	nt)	19b. Maili	ng Address (Street		or Rural Route Numb		···	p Code)	_
	1 and 2 Health ar am 27 Is		VONELL LEONARD /POA		68 L	EONARD DRIV	/E, GERR	ARDSTOWN, WV	25420)		
ore	ges 1 au t of Hea lfitam or otha		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Remove		20b. Place of Dispo	osition (Name of	э) ј	ANUARY		ation - City or T		
altimore,	Pag tment tant:		* 4 ☐ Donation 5 ☐ Other (Specify)		I LLADANI Y	TEVY MEMORY	6	, 2004		INSBURG,		
Ball	permit, Pages 1 Department of H Important: If its any injury or ott		21. Signature of Funeral Service Licensee	Beaus		2. Name and Addre ROWN FUNERA	ss of Facility L HOME,	P.O. BOX 82	1, 327 RTINSE	W. KING BURG, WV 2	ST., 25402	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	that caused the	e death. Do not en	ter the mode of dyin	ng, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Bett Onset and I	ween
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	neul	nonia						4841	5
	/Medical Examiner		rossing in assin,	Due to (or as a c	onsequence of):							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa Cicase of it jury	Due to (or as a c	onsequence of):							
	cuted	Examine	cause. Enter Underlying Cause (Siceass of Figur) that initiated events c	_								
0,	ө өхө lan ar urial-t		resulting in death) Last	Due to (or as a c	onsequence of):							
8760,	icate be executed physician and s the burial-transit	dica	d									
9 X	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23c. If y	es, outcome of	pregnancy				2	3d. Date of deliv	1051	
Вох	d for u	cian	in the past 12 months?	Live birth 2 [] Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	<i>'</i>		2.	Month	•	/ear
P.O.	t the de by the a tached	hys	9 ☐ Unknown 9E	Unknown				-				
	res tha igned I be det	by P	Part II. Other significant conditions contributi	ng to death but r	ot resulting in the u	nderlying cause giv	en in Part I.		2	se contribute to t		
Vital Records,	v requir been si should								Yes 2	Mo 3□Pro	babiy 4 □L	Jnknown
Sec.	e taw has b je 2 st	Completed						24a. Was		24b. Were auto prior to co death?	opsy findings a empletion of ca	available ause of
a		e Co	SE Management					1 ☐ Yes	200 No	1 🗆 Yəs	2□ No	
₹	Physician: 1 this certifical ral director, p	80	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	l: 1 Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Oth		if Death (Check only only only only only only only only		Other (Speci	60	
of		<u>ان</u> کو	27. Manner of Death 28a	Date of Injury (Month, Day Y			y at	28d. Describe			'Y)	
io	토글동글	atio	2 Accident investigation	(Mornin, Day 1	ear/ Injury		Yes 2 □ No					
Division	I or Atteno after deatl Diractor: I in by the	Certification;	3 Suicide 6 Could not be determined 28e	. Place of Injury building, etc. (At home, farm, str Specify) 	reet, factory, office		28f. Location (: City or To:	Street and wn, State)	Number or Rur	al Route Num	ber,
	To tha Hospital or Attanuwithin 24 hours after deatl To tha Funaral Diractor:		29a. Certifier 12 Certifying Physician:	To the best of n	ny knowledge deat	h occurred at the tin	ne, date and	place, and due to the	cause(s)	and manner as	stated	//
	To tha Hospital within 24 hours a To the Funaral completely filled	edical	(Check only 2 Medical Examiner: O	n the basis of ex id manner stated	amination and/or in	vestigation, in my o	pinion, death	occurred at the time,	date and	place, and due t	o the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)	
	Δ.		note			D5	232	.3	1-1.	3-200	04	
Ď	7		30. Name and address of person who complete			•		O.T.O.L.				
9		10	DR. KHALID WASEEM,	19414C 32. Registrar's		JRG PIKE,	HAGER	STOWN, MD	2174	2		
	Sta Registi		31. Date filed (Month, Day, Year) JAN 20 2004	Miner	a B. p.	perte						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Day Year John Harrison MOORE January 15 2004 2:20 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clearview Nursing Home Washington Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 ★M 2 □ F **Director** 92 July 13 1911 Pennsylvania 220-18-0421 Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Madical Examinational be notified at 1 X Yes 2 No Directo Maryland Washington Funkstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 W. Baltimore Street 21734 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. tiled within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specity: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Manager Car Dealer permit. Pages 1 and 2 should be tiled Department of Health and Mental Hygi Important: if item 27 is merked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gotleib Scherpf Caroline Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Henrietta E. Moore - Wife 40 W. Baltimore Street Funkstown, Md. 21734 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Episcopal Cemetery 1/19/04 Danville, Pa. 21. Signature of Euroral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anterio S Churchia /Medical Due to (or as a consequence of): Examiner Almy 5. bulleti m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certiticate be executed physician a Due to (or as a consequence of) Box 68760, Physiclan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy to in the past 12 months? Year Month Day 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, 99 Dirtin Mechilins Proporte 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Accile 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Venader 24a. Was an autopsy performed? Division of Vital 1 Tyes 2 ₹ No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter 1 GNatural 5 Pending s after decreal Director: Atte investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lilled in by 4 Homicide 24 hours a Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hou To the Fune completely li (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -tout no D18019 JAN 15, 2004 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARERSTOWN, MO 21740 DATTA MO MILL ST 340 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 20 2004 and water Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-	For State Registrar	Otate of Ivid	arytaria /		ificate of l	Death	-	Reg. No. 200	4 02708			
		1. Decedent's Name (First, Middle, Last)				<u> </u>		2. Date of De. Month	ath Day Yea	3. Time of Death			
Physicia /Medica		Glenton Charles MI	ENTZER					Januar					
Examine		4a. Facility Name (If not institution, give s	treet and number)			•	Location of Death		4c. County of De				
		Reeders Memorial H			* d b d	Boon If Under 1 Year	sboro If Under 24 Hrs.	O Data of Bio	Washin	9			
Funeral Director		214-09-3442		91	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da Aug. 16	, Year) ,1912 Ma	irthplace (State or Foreign Country) aryland			
and **	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loca	ation				10d. Inside City Limits			
Maryl f sho	ŏ	Maryland Washir	gton		Hag	erstown				1 ☐ Yes 2X No			
r 286	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?			
23e o	Funeral Director	313 Daycotah Aver	iue			2	1740		USA				
ems erns	iner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Ar Black, W	nerican Indian, nite, etc.			
urs a	<u>م</u>	1 ☐ Never Married 2 A Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔼 N If Yes, Give Year or Dates:	lo	1	□Yes 2⊠ No			Specify:	white			
72 hc	etec	15. Decedent's Educ (Specify only highest grade	cation completed)	168	. Decede (Give ki	nt's Usual Occupa	ation furing most of worki)	ing	16b. Kind of Busines	ss/Industry			
vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		ONOTuse retired inist)		machine				
Hygie Hygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)	0		macii.	IIIISC	18. Mother's Name	(First, Middle,		acturer			
d be ental	To Be	Earl K. Mentzer					Mabel B						
shoul nd Me meri	F	19a. Informant's Name/Relationship (Type	pe, Print)	19	b. Mailing	Address (Street a	and Number or Rura	I Route Numbe	r, City or Town, State	, Zip Code)			
alth a		Dorothy V. Mentzer	- wife	3	13 Da	aycotah .	Ave., Hag	erstown	, Maryland	1 21740			
es 1 a of He of He rothe		20a. Method of Disposition 1X□ Burial 2 □ Cremation 3 □ R	amoust from State	20b. Place o	of Disposi ery, crema	tion (Name of atory or other plac	e) [Date	20c. Location - City	or Town, State			
Page ment ant: Ji ury o		'4 □ Donation 5 □ Other (Specify)	amovai nom state	Rose	H <u>i</u> 1:	l Cemete	ry 1/17	/04	Hagersto	own, Maryland			
permit. Departimport any inj	21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL 415 E. Wilson Blvd., Hagerstown,												
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Physician		Immediate Cause (Final disease or condition		Interval Between Onset and Death									
/Medical		resulting in death)		7									
Examiner		Due to (or as a consequence of): Sequentially list conditions, The to (or as a non-secuence of):											
ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
rificate be executed by physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence	of):								
			1										
tificate g phy as the	Medical		•										
		230. was decedent pregnant	3c. If yes, outcome of 1□Live birth		h 3∏E	Ectopic pregnancy			23d. Date of c	·			
Attending Physician: The law requires that the death cerdeath. death. sctor: After this certificate has been signed by the attendit by the funeral director, page 2 should be detached for use	Physiclan/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown			Other (specify)			Month	Day Year			
that the ed by detac	Ę.	Part II. Other significant conditions con	itributing to death bi	ut not resulting	in the unc	derlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?			
signe d be	d b	Mypolagicalin	-	-		scone		101	′es 2 □ No 3 □	Probably 4 🖫 nknown			
w require been si should t	ete	A						24a. Was	an 24b. Were	autopsy findings available			
he lav e has age 2	Completed	menna						autop perfo	rmed? [death	autopsy findings available o completion of cause of			
ysician: The is certificate hidirector, page	a l	25. Was case referred to medical					26. Place of Death		2 1 Y	es 2 No			
Physici this cer al direc	ToB	examiner?	lospital: 1 🗆 Inpatie	nt 2□ER/O	utpatient	3□ DOA Othe			lence 6 Dother (Sp	pecify)			
ng Ph fter th		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry Year) 28b.	Time of Injury	28c. Injun Work		28d. Describe I	now injury occurred				
Attending P death. ictor: After I	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2 □ No						
or At offer d Diract in by	Certification;	4 Homicide determined	28e. Place of Injubulding, etc		arm, stree	et, factory, office		City or Tox	Street and Number or vn, State)	Hural Houte Number,			
spital ours a seral I		29a. Certifier 1 Certifying Phys	sician: To the best	of my knowledo	e, death	occurred at the tim	ne, date and place.	and due to the	cause(s) and manner	as stated.			
To the Hospital or Attendi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	edical		ner: On the basis of and manner sta	examination a	ind/or inve	estigation, in my o	oinion, death occurr	ed at the time,	date and place, and d	ue to the cause(s)			
To th withir To th comp	ž	29b. Signature and title of certifier				29c. License			29d. Date signed (Mo				
,		-13/12	MO			D	8019		JAN 15,	2004			
(X,2)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vasant Datta 340 Mill Street, Hagerstown, Maryland 21740 / 301-739-7100												
5H 611		Dr. Vasant Datta 34 31. Date filed (Month, Day, Year)	32 Benistre	treet, ar's Signature	Hage'	rstown,	Maryland_	21740 /	301-/39-7	100			
Stat Registra		31. Date filed (Month, Day, Year) JAN 15 20	04 Agree	w B.	Sp	whit							

			1 - For Stata Registrar	State of M	aryland / I		artment of I		and M		iene _{eg. No.} 20	0 5	02709
ı	Physici /Medic		1. Decedent's Name (First, Middle, Las George Newton McCa	•						2. Date of Deat Month		Year 204	3. Time of Death
	Examin		4a. Facility Name (If not institution, give 663 Hayes Avenue	street and number;			4b. City, Town, Hagerst		f Death		4c. County Washir		
	Funeral Director		236-22-5132	x 7. Aq XM 2□F	ge (In yrs. last bi 81	rthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day, 07/10/19		9. Birthpla Count	ace (State or Foreign ry) WV
	show	'n	Usual Residence of Decedent 10a. State 10b. County MD Washing	on	10c. City, Tow Hagers				44			10	0d. Inside City Limits 1 X Yes 2 □ No
	with the N a or 28a-f be notiffi	Direct	10e. Street and Number		110.601.0		10f. Zip Code 2174	0		1	Og. Citizen of W	/hat Count	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinant mat be neitlised at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 XYes 2 If Yes, Give Year or Dates:	7	1	Vas Decedent of life Yes, specify Cub	Hispanic Original, Mexican	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	14. Race	e America k, White, e	tc.
Maryland 21215-0036	filed within 72 ho Hygiene. kher then "natur snt, Ir e M olcal	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			(Give lite. I	lent's Usual Occu kind of work done DO NOT use retire Detaile	during most id)	of workir	ng	16b. Kind of Bu	siness/Indi	
yland	should be file ind Mental Hy is marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) George Newton McCa					Mar	guer	(First, Middle, M rite (un	k) Holl	.ybast	
e, Mar	is 1 and 2 shi of Health and item 27 Is m other traum		19a. Informant's Name/Relationship (7) James N. McCann /		3	8 W.	g Address (Street Howard	Street	:, На	gerstow	n, MD 2	1740	
Baltimore,	Pages 1 tment of H tant: If ite jury or ot		20a. Method of Disposition 1)		Hill	sition (Name of natory or other pla Cemete:	<u>ry</u> 0	1/16		Hagers		
Ba	permit. Departn Imports any inju		21. Signature of Funeral Service Licens	X		3	Name and Addre	tomac	Stre	et, Hag	erstown	, MD	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each l	of the death. Do ine.		-	_					Approximate Interval Between Onset and Death
8760,	Medical Examine physician and the burial-transit the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate sease. Exter Underlying Cause, (Disease or injury	b. Due to (or as	a consequence	OI).	en e	fun		t ffre	T		
P.O. Box 6	ath certific	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pregnanc Other (specify)	у			23d. Date Mon	of delivery	y Day Year
	w requires that the de been signed by the a should be detached f	ρ	Part II. Other significant conditions co	ntributing to death t	_				Lieo		_		cause of death?
Vital Records,	i: The law requicate has been ; page 2 should	Completed		suse	,					24a. Was ar autopsy perform 1 Yes 2	ned? pi	rior to comp eath?	sy findings available pletion of cause of 2 No
	Physician: Th this certificate al director, pag	To Be	11A 162 2 140	fospital: 1 ☐ Inpati		-	3U DOX	ner: 4 □ Nur		<i>(Check only one</i> ne 5 Z #Reside		r (Specify)	
Division of	ding After fune	Certification:	27. Manner of Death 1 ♣Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Inju (Month, Da	iry 28b. iy Year) I	Time of Injury	28c. Inju Wo M 1 □	yat rk? Yes 2 □ N		8d. Describe ho	w injury occurre	d	
<u>X</u>	a g g e		4 Homicide determined	28e. Place of In building, et	ury - At home, fa c. <i>(Specify)</i>	arm, stre	eet, factory, office		2	8f. Location (Str City or Town,		r or Rural i	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	ledical	29a. Certifier (Check only one) 1□ Certifying Phy 2 Medical Exam	sician: To the best nar: On the basis o and manner st	f examination an	e, death id/or inv	estigation, in my o	pinion, death	i place, a h occurre	d at the time, da	ite and place, a	nd due to t	he cause(s)
		Σ	29b. Signature and title of certifier	Dit	0111	1-1	29c. Licens	> - (O (62		an 1d		ay, Year)
5H	ax1		30. Name and address of person who c	ompleted cause of c	leath (Item 23a)	(Type,	266	011	c to	char a	(twi	164	42
	Sta Registr		31. Date filed (Month, Day, Year)	32 Aegistr	ar's Signature	Sp	which	ų.		, , ,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January, Day, 2004 **Physician** 7:45 P M Mildred Mathias /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/23/1912 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F 214-09-1221 91 VA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in then "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 X Yes 2 No Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 13207 Fairfax Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0.0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elisha Averett Jenkins Julia Virginia Balt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trea 18310 Montgomery Village Ave, #400, Gaithersburg, MD John I. Heise / Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cremator. 01/12/2004 Smithsburg, MD 21. Signature of Funeral Service Licensée 22. Name and Address of Facility Gerald N. Minnich Funeral Home 23a. Part1. Enter the disease, 305 N. Potomac Street, Hagerstown, MD 21740 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician 10 days Memoria resulting in death) /Medical Due to (or as a consequence of): Examiner Demento. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes No Other: Nursing Home 5 Residence 6 Other (Specify) ပ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Division To the Hospitel or Attending 1 Natural 5 Pending investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 028365 cause of with (Item 23a) (Type, Print) DSHAM 368 Hagestone 32. Registrar's Signature State Registrar

			For Stete Registrar		State of	Marylar	•	artmen rtificat			and M	ental Hy	giene Reg. No	CULL	0271	· Contraction
	Physici /Medic		1. Decedent's Name (First, Mid Christopher M		inds							2. Date of De Month Januar	у 9	, 2004	3. Time of Death 22:18	VI
	Examin Funeral	er	4a. Fecility Name (If not institute Union Hospita 5. Social Security Number	of (Cecil_	County 7. Age (In yrs.		4b. City, E1k If Under Months	ton	If Under		8. Date of Birt (Month, Da	th y, Year)			 gn
	Director		221-60-9560 Usual Residence of Decedent 10a. State 10b. Coun		W 2 L F	42	Yrs. ty, Town or Lo					March			Delaware 10d. Inside City Limit	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Evantral must be rotified at once.	Director	Delaware Nev	Cast	11e		Newa	10f. Zip						izen of What C	•	0
980		1 by Funerai	19 Queens Way 11. Marital Status 1 Never Married 2 Marital 3 Widowed 4 Divorce	ırnied	Mas Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	2 X No ∍		_				ecify Yes or No Rican, etc.)		ited St 14. Race - Am Black, Wh Specify:	erican Indian,	
Maryland 21215-0036		Completed	15. Deced (Specify only high Elementary/Secondary (0-12 12	est grade	tion completed) College (1	4or 5+)	life.	dent's Usua kind of wo DO NOT us clift	rk done a se retired	luring mos)		ng		ind of Business		
ryland		To Be C	17. Father's Name (First, Middle Frederick J. 1	1cMin			10h Mo20	a Address	Strant	Jos	ephi	(First, Middle, ne Garr	ahai	,	Zin Codel	
Baltimore, Mai			Frederick J. I 20a. Method of Disposition 1 X Burial 2 Crematio 4 Donation 5 Other 21. Signature of Funeral Services	icMino a 3 ⊟Rea (Specify)	ds/Fat	20b. I	417 V Place of Dispo cometery, crei	Nooda sition (Nar matory or o	le Ar ne of other place Ceme	venue ⁹⁾ J	Ne Ianua 20	w Castl Pate ry 14, 04	20c. Lo		e 19720 r Town, State ton, and	
	Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, shock, or heart failure. L immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or complicits only one a. b. c. d.	Due to (ach line.	th. Do not ent	er the mod	e of dying	g, such as				ast, Ma	Approximate Interval Between Onset and Death One day	
	the death certify the attending tched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	1 ☐ Live bi	come of pregn inth 2 Feta ant at time of d	aldeath 3]Ectopic pi] Other <i>(sp</i>						23d. Date of de Month	elivery Day Year	
<u>α</u>	en signed	þ	Part II. Other significant cond	tions control	Theis	ath but not res	sulting in the u	nderlying o	ause give	en in Part I			obacco (Yes 2		to the cause of death? Probably 4 Monknow	'n
Vital Records,		Completed	Gastro	ascu Intest	leval	Accid	ent					1 ☐ Yes	osy ormed? 212 No	prior to death?	utopsy findings available completion of cause of	е
of	Attending Physic death. ctor: After this ce y the funeral direc	ation: To Be	25. Was case referred to medical examiner? Town Hospital: 1 Impatien Town Hospital: 1 Impatien Town Town Impatien I													
Division		Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	To the Hospital or I within 24 hours after To the Funeral Dirac completely filled in b	Medical	(Check only 2 Medic one)	al Examin		sis of examina		vestigation	, in my of	oinion, dea			date and		e to the cause(s)	
)	To T Com	2	29b. Signature and title of certi	Aa	elid	er 81	10			number 233	22			te signed (Mor		
-	4		30. Name and address of pers	EU M	10	1181	Nort	Print)	rut	33	E.	etaton	m	mary 219:	2/	
	Sta Regist	ate rar	31. Date filed (Month, Day, Ye JAN 1 4 200	4	Lagran S	egistrar's Sign	Acerti	,								

Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** Pierson 15,2004 Huntley Irene Louise 7:35 pm January /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Williamsport Washington Homewood 8. Date of Birth October 77,1910 9. Birthplace (State or Foreign Providence, RI If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 93 Yrs. If Under 1 Year 5. Social Security Number **Funeral** Days 1 M 2 F Months 004-30-4473 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County other traumatic event, the Medical Examiner must be notified a 1 ☐ Yes 2 No Completed by Funeral Director Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21795 United States 16505 Virginia Avenue 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? . Raca - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 💢 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 Vice President Automobile Dealership 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Peges 1 end 2 should be f nent of Health end Mental I int: if item 27 is marked ot Floyd J. Huntley Iola Willson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pam Parziale-Daughter Road, Kearneysville, WV 25430 Paynes Ford 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/17/04 Winchester VA injury Omps Crematory 22. Name and Address of Fecility 21. Signature of Funeral Service Ligensee Melvin T. Strider Funeral Home Post Office Box 388, Charles Town, WV 25414 Delications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, OSEALDY 23a. Part 1. Enter the disease, or sank, or heart failure. List only plications that cause the Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 45cm F 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident Division 5 Pending investigation or Attending 1 🗆 Yes 2 🗆 No within 24 hours efter deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner es stated. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner steted. 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 000 ted cause of death (Item 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

		1. Decedent's Name (First, Middle, La	ast) Belle	Dr Cei			2. Date of Dea Month	ath Day Yeer	3. Time of Death		
/sicia ledica		Reva	Bell-	Parki	nson		Januar		1:30 A.		
amine	_	4a. Facility Name (If not institution, gi				Location of Death		4c. County of Dea			
	1	1044 Benjamin Pla			Hagersto		T	Washing			
eral ctor		5. Social Security Number 6. 219–14–7666	Sex 1 □ M 2 AF 7. Ag	e (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, De) Oct. 1.	y, Yeer) 9. Bi 5, 1923 Mai	irthplace <i>(State or Fore</i> Country) ryland		
		Usual Residence of Decedent							10d. Inside City Lim		
3		10a. State 10b. County		10c. City, Town or Lo	ocation				1X Yes 2 □ N		
the Medical Examiner insist be notified at	Director	MD Washing	gton	Hagerstow							
2	吉	10e. Street and Number	1		10f. Zip Code			10g. Citizen of What C	country?		
		1044 Benjamin Pi		5	21742	innania Osigia 2 /Sr	posify Voc or No.	U.S.A.	nencan Indian		
	Funeral	11. Marital Status1 ☐ Never Married 2 Married	12. Was Decedent Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Bleck, Wh			
	by F	1 ☐ Never Married 2 ≥ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	NO	1□Yes 2XNo	Specify:		Specify: Wh	ite		
6	ed	15. Decedent's I		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busines:	s/Industry		
å l	bet	(Specify only highest g	rade completed)	life.	kind of work done of DO NOT use retired	during most of world)	ang				
	Completed	Elementary/Secondary (0-12)	College (1-4or 5		maker			Own Home			
2	BeC	17. Father's Name (First, Middle, Las	st)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)			
	ToB	Samuel M. Shacke	lford			Mary J.	Eyler				
		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ing Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town, State,	, Zip Code)		
		Calvin E. Parkin	son/Husban		Benjamin				1742		
	1	20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	e)	Date	20c. Location - City o	or Town, State		
		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			en Cemete	1	/2004	Hagerstown	. Marylan		
once.		21. Sign turn of Funeral Jervic Lic	ensee					n Funeral (Chape1		
a		12 - 7	1	1	601 Penns	ylvania .	Avenue,	Hagerstown	n, Md. 217		
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death. Do not en					Approximate Interval Between		
n		Immediate Cause (Final	y one cause on each	7).		uncer			Onset and Death		
i	1	disease or condition resulting in death)	a Due to (or as	a consequence of):		un cet			237.00		
r											
	Jer	Sequentially list conditions, it any, leading to influed late cause. Enter Underlying	Due to (or as a consequence of):								
	Examiner	that initiated events		1							
	EX	resulting in death) Last	Due to (or as	a consequence of):					1		
-1	Ical		d						-		
	Physician/Med	IF FEMALE:		- G.19 V - L.E.			-				
	an/I	3b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy						23d. Date of d Month			
1	SICI	1 ☐ Yes 2 ☐ No	4□Pregnant a 9□ Unknown	it time of death 5	Other (specify)						
	Phy	9 Unknown			and arbitant against and	on in Part I	23a Did t	obacco use contribute	to the cause of death		
	by	Part II. Other significant conditions	contributing to death t	but not resulting in the	underlying cause giv	ын наган.		/	Probably 4 □Unkn		
	ted										
	Completed						24a. Was autor		autopsy findings avai o completion of cause		
	Son						1 ☐ Yes				
completely filled in by the funeral director, page	Be (25. Was case referred to medical examiner?			101	26. Place of Dea	ith (Check only o	one)			
	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati			4 Hursing I	dence 6 Other (Sp	oecify)			
	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	ury 28b. Time ay Yeer) Injury	Wor		how injury occurred					
	Certification;	2 Accident investigat 3 Suicide 6 Could no	ho	Yes 2 □ No	28f Location /	Street and Number or i	Rural Route Number				
	H	4 Homicide determine	. J ZSA PIACE OF IT	njury - At home, farm, s atc. <i>(Specify)</i>	ured, ractory, office		City or To				
		COn Continue 4000-441-	Physicien: To the best	t of my knowledge de-	ith onguered at the "	me date and place	and due to the	cauca(c) and manner	as stated		
	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	eminer: On the basis aminer: On the basis and manner s	of examination and/or i	investigation, in my o	ppinion, death occu	irred at the time,	date and place, and d	ue to the cause(s)		
	Jed	29b. Signature and title of certifier	and manner s	natou.	29c. Licens	se number		29d. Date signed (Mo	onth, Dey, Year)		
	200	organizate and the or contine		/							
	-	Da 1	1 Unas		10 0	4/1/		1.16	011		
no de la companya de	-	30. Name and address of person	J. med	and M	0 0	41667		1.15	.04 MC		

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Day **Physician** Laura Ellen Poe 8, 2004 4c. County of Death /Medical 4b. City, Town, or Locetion of Deeth 7:35 PM 4e. Fecility Neme (If not institution, give street and number) Examiner 11 Maryland Avenue Chesapeake City Ceci1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Months 1 □ M 2 X F May 24, 1948 Delaware 10d. Inside City Limits 1 ☐ Yes 2XXNo 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1, Box 308, Buffalo, West Virginia 25033 20c. Location - City or Town, State West Chester, PA 259 E. Main Street Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. unknown 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and tife of certifier 29d. Date signed (Month, Day, Year) 29c. License number Saelder 8111) 20023322 1, 14,04 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

S. S. SACHDEN MD 118 North St Suite 33, E-lktm MD 2192/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 6 2004

State Registrar

			1 10030	State of Maryland / D	enartment of h	Health and M	fental Hydi	ne Legible. ene		
			1 - For State Registrar	Otate of Waryland / E	Certificate of	Death	Re	g. No. 2001	+ 02716	
	. 🦿		Decedent's Name (First, Middle, Las				2. Date of Death		3. Time of Death	
	Physici		Paul Ed	ward Poteat			Jan 15,	2004 Year	11:30 A M	
7	/Medie Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	or Location of Death		4c. County of Dea	ath	
В			10812 Knoll Cou	rt	Upper	Marlbord)	Prince	George's	
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs. last birti	Months Days		8. Date of Birth	Year) 9. Bi	rthplace (State or Foreign country) rth Carolina	
	Director			0 M 2 □ F 85	rs.		March 3	, 1918 No	rth Carolina	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits	
	daryl f sho	ō	Maryland Prince G	loorgo!a Unnor	Marlboro				1 ☐ Yes 2 ☐ No	
	288-	Director	10e. Street and Number	eorge 2 opper	10f. Zip Code		10	g. Citizen of What C		
	3a or	<u></u>	10812 Knoll C	Court		772		United St	*	
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23e or 28e-f ehow event, the Medical Exatilier missible traditied at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of I	Hispanic Origin? (Sp		14. Race - Am	encan Indian,	
9	or ite	Ē	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2.F录No If Yes, GiveA.A.			Rican, etc.)	Black, Wh	ite, etc.	
8	raf',	d by	3 Widowed 4 Divorced	Year or Dates:	1 ☐ Yes 2 📆 Xio	Specify:		Specify:	hite	
ς.	72 h natu	Completed	15. Decedent's Ed (Specify only highest grad		Decedent's Usual Occup (Give kind of work done	during most of work	ring	6b. Kind of Business	s/Industry	
2	vithin ne. han	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use retire .ergy	d)		Assembly	of God Churc	
2	lled v lygie ther t		17. Father's Name (First, Middle, Last)			19 Matharia Nam	e (First, Middle, Ma			
and	ntal hed od od	Be	Harrison Pot	oot				Ť		
2	hould d Me mark matic	2	19a. Informant's Name/Relationship (7		Mailing Address (Street		rude Gibs		Zin Codol	
Maryland 21215-0036	d 2 s th an trau		Paul E. Poteat,		0812 Kno11					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, the Medical Evaluate must be medified at ance.		20a. Method of Disposition	20b. Place of	Disposition (Name of		Date 20	Oc. Location - City or	Town, State	
9	Pages ent of nt: If i		1 XX Xurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Hemoval from State	, crematory or other pla Hill Cemete	1	2004 5	uitland l	Maryland	
≣	ortar inju		21. Signature of Funeral Service Linen.	500	22. Name and Addre	ess of Facility T.e.	Funeral	Homo To	c 6633 01d	
ñ	Depa Impo eny ir		Mario L. Horn	4 moo251	Alexandri	a Ferry R	oad. Clin	nome, in iton Mary	land 20735	
	0,8		23a. Fart1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do no					Approximate Interval Between	
¥.	Physician	Examiner	Immediate Cause (Final disease or condition	Cerebrovascu	lar Accider	n+			Onset and Death	
	/Medical		resulting in death)	a. Due to (or as a consequence o						
*	Examiner		Sequentially list conditions	b						
	D #		Sequentially list conditions, Tary, leading to ammediate cause. Enter Underlying Cause (Disease or injury							
	and trans	cam	that initiated events resulting in death) Last	C.	44.					
760,	ate be executed hysician and the burial-transit	cal E		Due to (or as a consequence o	1):					
687	physicate sthe			d						
	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy				024 Date of de	16	
Вох	atten for u	clan	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	у		23d. Date of de Month	Day Year	
o.	that the death red by the atter detached for	ysl	1 Yes 2 No 9 Unknown	9□ Unknown	o la cuita (aposity) _					
۵.	res that signed b	by Pł	Part II. Other significant conditions co	ontributing to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?	
g	quire; n sign	d b					1 ☐ Yes	2 □ No 3 □ P	robably 4 XXnknown	
၀	aw requin s been si 2 should	Completed					24a. Was an	24b. Were a	utopsy findings available	
Re	The lav	E					autopsy	prior to death?	completion of cause of	
Vital Records,		a	25. Was case referred to medical			26. Place of Death	1 ☐ Yes 2 (Check only one)	[]Xlo 1 ☐ Yes	3 2 □ No	
	Physician: this certific at director,	To B	examiner? 1 ☐ Yes 2 X CXNo	Hospital: 1 Inpatient 2 ER/Out	patient 3 DOA Oth	OF.		ce 6 ☐Other (Spe	ecify)	
0	ng Pt Iter th neral		27. Manner of Death 1XX Natural 5 ☐ Pending	28a. Date of Injury 28b. Ti	me of 28c. Injur	y at	28d. Describe how	injury occurred		
Division of	Attending Physician: r death. ector: After this certific by the funeral director,	ath	2 ☐ Accident investigation		Yes 2 □ No					
ž		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fam building, etc. (Specify)	m, street, factory, office	factory, office 28f. Location (Street and Number or Rural Route No. City or Town, State)			ural Route Number,	
Ω	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fur	S		1						
	Hosp 14 hou Fune tely fi	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of my knowledge, iner: On the basis of examination and	death occurred at the till for investigation, in my d	me, date and place, opinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	s stated. a to the cause(s)	
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and manner stated.	29c. Licens					
	7 × 5		Wate	alletter		23743	290	I. Date signed <i>(Mon</i> i Jan 15,	• •	
			20 Name and address of	amelated source of the first		3143		Jan 1J,	2004	
1	BIN		30. Name and address of person who of Martin Wertz. M.I	ompleted cause of death (Item 23a) (1). 7525 Greenway C	• • • • • • • • • • • • • • • • • • • •	Greenbel	t. Marvla	and 20770		
41	Sta	te	31. Date filed (Month, Day, Year)	22 Barfatraria Cinnatura			-,	20110		
	Registr		JAN 2 1		Sperte					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) :15 AM **Physician** QUETO SANUA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Feb. 27, 1974 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 234-19-3908 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🖾 F 29 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County WVJefferson 1 ☐ Yes 2 ☐ No Summit Point Director 10e. Street and Number 1922 Shirley Road 10f. Zip Code 10g. Citizen of What Country? 25446 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I □ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cachier 12 Food Market 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles E. Martini Janet Ramsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1922 Shirley Road, Summit Point, WV 25446 Albert Anthony Queto/Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition etery, crematory or other place) View Church Cemetery 1/24/04 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Inwood, WV ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Litoensee 22. Name and Address of Facility
Melvin T. Strider Co., Inc. 23a. Part. Effer the visease, or complications that caused the shown heart failure. List only one cause on each line. INPISTIBLE death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYELOGEN OUS LEUKEMIA Physician 2 YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially 1st concilors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 1 ∏ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? certificate has 2 🗹 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 X Inpatient 2 ER/Outpatient 3 DOA Director: After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 ⊠Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I disabethit Spift this RES-000 JANUARY 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELIZABETH A. GRIFFITHS, JOHNS HOPKINS HOSPITAL, GOON WOLFE STEEFT, BAUTIMORE MD 21287 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	1arylan		artmer <i>rtificat</i>					giene Reg. No.	2004	02	718
	Physici /Medic		Decedent's Name (First, Middle, La Bra		RO	OLL					2. Date of Dea Month Januar	Dav	, 2004	3. Time of E	
	Examin		4a. Facility Name (If not institution, given 818 Queen Annes	Court			На	gers					ounty of Deatl ashingt		
	Funeral Director		570-70-6945	Sex 7. A 1 ⊠ M 2 □ F		3 Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day May 12	1950	9. Birth Con Wis	pplace (State or intry) COnsin	Foreign
	Maryland e-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washin	gton		y, Town or Lo				_				10d. Inside City	
	th with the 23s or 28 1st be not	al Dire	10e. Street and Number 818 Queen Annes	Court			10f. Zip		740				on of What Co.	untry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depermitment of Heath and Mental Hygiene. Deperment: If them 27 is marked other than "natural", or iteme 23a or 28e-f show any injury or other treumatic event, the Modical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ② Divorced	12. Was Deceder Armed Forces 1 XYes 2 If Yes, Give Year or Dates] No		Was Dece If Yes, spe 1 Yes		spanic Ori n, Mexican Specify:		ecify Yes or No- Rican, etc.)		Black, White Specify: W		
21215-0036	within 72 ho lene. r than "natur the Medical	ompleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 0-12	ducation ade completed) College (1-40	r 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u			t of worki	ing		of Business/I		
Maryland 2	uld be filed Jental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Las Robert) M. Roll							e <i>(First, Middle,</i> e Sarriı				
, Mary	and 2 sho salth and N n 27 Is me er treume		19a. Informant's Name/Relationship Clay Roll - bro			1012	5 St	. Geo		Circ.	le, Hage	ersto	wn, Ma	ryland :	21740
3altimore,	Pages 1 ment of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Special Content of the Conten		е с	Place of Disposementery, created to the series of the seri	matory or o	other place		anua	ry 2004		ation - City or Terstown	own, State , Maryl	and
Balt	permit. Depertiumport any inj		21. Signature of Funeral Service Lice	Stal				. Wi	1son	Blvd	IINNICH ., Hage	rsto		21740	
	The law requires that the death certificate be executed by the standing physicien and be detached for use as the burial-transit by the burial-transit to be used.	dicai Examiner	23a. Pert1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a c. Due to (or a d. d.	is a consequence of the conseque	Vair Gence of): Lucy Lucy Lucy Lucy Lucy Lucy Lucy Lucy	l n	ter C	015	ta	sis on_			Approximate Interval Betwo	ths
O. Box 6	w requires that the death certifical been signed by the ettending planding blanding	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fete	death 3	⊒Ectopic p ⊒ Other (sp					23	d. Date of delin	very Day Ye	ear
rds, P.	quires that I in signed by uld be deta	þ	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	inderlying o	ause give	en in Part I.		~	es 2 🗆		the cause of dea	
Il Records,	The law re cate has bee page 2 sho	Completed			<u> </u>						24a. Was a autop perfor 1 Yes	an sy med? 2)K No	24b. Were aul prior to c death? 1 \(\text{Yes}	opsy findings avompletion of cau	vailable use of
Vita	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatier	nt 3 DC	Othe	\r.		n <i>(Check only or</i> me 5 ☐ Resid	1	Öther (Spec	Broth	rent.
Division of Vital	Attending Physician: r death. ector: After this certifics by the funeral director,		27. Manner of Death Natural 5 Pending 2 Accident investigation		ijury Day Ye <i>ar)</i>	28b. Time o Injury	M S	28c. Injury Work 1 🗆 \	rat ⟨? (es 2 □		28d. Describe h	ow injury	occurred	110	
Divis	호육등등	Certification:	3 Suicide 6 Could not l	250. Place of I	njury - At he etc. <i>(Specif</i>	ome, farm, str	reet, factor	y, office			28f. Location (S City or Tow	treet and n, State)	Number or Ru	ral Route Numbe	ər,
	To the Hospitel within 24 hours e To the Funerel I completely filled	edical		hysicien: To the bes miner: On the basis and manner:	of examina										
\	To the within 2 To the complet	Σ	29b. Signature and title of certifier		1	001	29	c. License	number	M	2 -	29d. Date	signed (Month	Day, Year)	no/
2H	6		30, Name and address of person who	completed cause of	death (Item	1 23a) (Type,	Print)	PAI	- (T.	Had	Jon 1	Hown	M	2174
	Sta Registi		31. Date filed (Month, Pay, Year)	2004 32. Regis	strar's Signa	iture	Sparke				1100	J	- 1 - 1 - 1	ق لي الدي	N. I. F.

			For State	State of Mar	•	artment of H			ene g. No. 2001	. 0271
			Registrar 1. Decedent's Name (First, Middle, Last))				2. Date of Death		3. Time of Death
	Physici		Katherine Elizabe					Jan.	13 2004	5:45 P M
5	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death		4c. County of Death	
	E Admin	٠.	12934 Woodburn Dr	ive		Hagersto	own		Washingt	on
	Funeral		Social Security Number 6. Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign
	Director		214-10-5504]M 2⊠F 9	13 Yrs.			03/18/19	910	PA
	pur *		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryk Poho	ō	MD Washingt	on	Hagersto	พท				1 X Yes 2 □ No
	28a-	Director	10e. Street and Number	011	падельее	10f. Zip Code		10	g. Citizen of What Cou	ntry?
	i within 72 hours after death with the Maryland jiene. r than "neturel", or terme 23a or 28a-f ehow the Mazical Examinational be notified at		12934 Woodburn Dr	ive		21742			USA	
	me 2:	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
٥	or Ite	F	1 ☐ Never Married 2 ☐ Married	1 ∐Yes 2 XNo If Yes, Give		1 □ Yes 2 No	Specify:	rican, etc.)		White
9500-6121	hours after turel', or fte	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:						
<u>ה</u>	"nett	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing 1	6b. Kind of Business/Ir	ndustry
	within 72 ene. than "nel	dmo	Elementary/Secondary (0·12)	College (1-4or 5+) 2.)	memaker	-/		Home	
and z	Hyg Hyg ent,	e Cc	17. Father's Name (First, Middle, Last)		110		18. Mother's Name	e (First, Middle, M	aiden Sumame)	
lan	d la la	To Be	Gustavos Jacob My	ers			Charlot	te Edith	Doty	
a 2	nd 2 should ith and Men 27 Is marks traumatic	_	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number,	City or Town, State, Zi	o Code)
, Mar	and 2 ealth a m 27 le		John M. Roche / S	on			re., Suff			
altimore,	-I 6-		20a. Method of Disposition 1 Straight 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac		Date 2	0c. Location - City or T	own, State
Ĕ			*4 □ Donation 5 □ Other (Specify)				tery 1/17		hicora, PA	
Ball	permit. Pag Department Important: I any injury o		21. Signature of Euneral Service Livens	***					Minnich Fur	
			23a. Part1. Enter the disease, or compl	ications that caused th					stown, MD	Approximate
	DI		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		Consequence of):	DUEN IRIC	JUAK N	DE HEAT	RI BLOCK	6 MONTHS
	Examiner		:		OSCUERUTI	C CORU	NARY AD	TERY A	VICEASIE	15 YERRS
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
	ecuted and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
3/60,	death certificate be executed e attending physicien and d for use as the burial-transit	ai E		Due to (or as a	consequence of):					
/89	phys phys s the	edicai	_	d						
XOR	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		7c			23d. Date of deliv	rery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at tii		Ectopic pregnancy Other (specify)			Month	Day Year
J.	by the a	hys	9 Unknown	9□ Unknown				7		
	es that igned b	by F	Part II. Other significant conditions co.	ntributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	1	acco use contribute to	
<u>0</u>	w require been si should t									bably 4 Unknown
Vital Records,	The law requires that the tite has been signed by the bage 2 should be detache	Completed						24a. Was an autopsy perform	24b. Were autoprior to condeath?	opsy findings available emptetion of cause of
E -								1 ☐ Yes 2	☑No 1 ☐ Yes	2 No
≅	ysician: The is certificate director, pag	Be	25. Was case referred medical examiner?	Hospital:		Oth		h (Check only one	·	
	Phys	. To	1 Yes 2 No	28a. Date of Injury (Month, Day	2 ☐ ER/Outpatier 28b. Time o			28d. Describe hov	nce 6 Other (Special vinjury occurred	79)
0	th. : After s funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		rk? Yes 2 □ No			
Division of	or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number.
	Hospital or At 24 hours after of Funerel Directely tilled in by	Cer	200 Contilion 1 Continue Phys	1			mo data and place	and due to the en	usa/a) and manner as	ntatod.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edicai			xamination and/or in				use(s) and manner as : te and place, and due :	
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Month,	Day, Year)
			Palet Bull P	CRSONAL	PHYSICH	AN D	10000	1359	JAN 1	4 2004
44	(-7		30. Name and address of person who co				,	01716		
ハ 	4 C4	to	Robert Brull, MD,	1459 Poto 200 32. Registrar	omac Avenu 's Signature ,	e, Hagers	stown, MD	21/42		
	Sta Registi		JAN 1 5	ZUU4 Ziller	some of the	and the				

Addie Louise

1	-	For State Registrar
4	-)acadant'a

State of Maryland / Department of Health and Mental Hygiene 2001; 02721

		State Registrar		Cel	rtificate of L	Jeam		Reg. No.	
		1. Decedent's Name (First, Middle, Las.	1)				2. Date of De	ath Day	3. Time of Death
hysicia/ Medic		DOROTHY RICHA	RDSON				JANUAF	Y 13,	2004 02:44
Examine		4a. Fecility Name (If not institution, give Saint Joseph		Center	4b. City, Town, or	Location of Deal		4c. County	of Deeth Baltimore
uneral rector		5. Sociel Security Number 6. Se 218–28–0962	7. Ag	80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir (Month, De Feb. 2	th (1923	9. Birthplace (State or Fore Country) Maryland
	İ	Usual Residence of Decedent			·				
how	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Lim 1 ☐ Yes 2 🔯
-	cto	Maryland Harf	ord	Ha	vre de Gr	ace			
or 28	Director	10e. Street and Number	_		10f. Zip Code	070		10g. Citizen of	
23a	a	565 Penningt				078		US	
tems er n	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puel	Specify Yes or No ito Rican, etc.)	Bla	ce - Americen Indian, ck, White, etc.
if item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avent, the Modical Examiner most be notified at	d by Funeral	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔯 I If Yes, Give Year or Dates:	40	1 ☐ Yes 2 🛣 No	Specify:			y: Black
alical	etec	15. Decedent's Ed (Specify only highest grad	ucation de co <i>mpleted)</i>	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of wo	orking	16b. Kind of B	usiness/Industry
the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	omestic			Privat	e Homes
vent, I	e	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Suman	ne)
arked o	ည်	Collins S. Williams	5				etta She		
ie m		19a. Informant's Name/Relationship (7			ng Address (Street a				
tem 27 i		Philip Richardson	n / son			Street,	Date		City or Town, State
H ita		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crea	matory or other plac				
Important: If itam 2 any injury or other once.		* 4 □ Donation 5 □ Other (Specify			s United		/16/04	Havre d	le Grace, MD
any in		21. Signature of Funeral Service Licen	500	22	2. Name and Addres Lisa S		neral Ho	me. P.A.	
= a a	0. 4	23a. Pent1. Enter the disease, or comp	0816	(Abordonia Donos	552 Le	wis Stre	et,Havr	e de Gra	CC, MD 21078
-2		shock, or heart failure. List only	one cause on each li	ne.	ter the mode or dyin	g, such as cardia	ic or respiratory a	111051,	Interval Between Onset and Death
sician		Immediate Cause (Final disease or condition resulting in death)	a CORON	ARY ARTER	Y DISEA	SE			4 YEARS
edícal miner		lesuring in death)	•	a consequence of): TAGE RENA	n relea	QC .			6 YEARS
	_	Sequentially list conditions, if any, leading to immediate	b	a consequence of):	1/1/1/17	.m. F			P. J. P. MILL
nsit	Examiner	Cause (Disease or injury		,					
af-tra	xar	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
sicial a buri	cail		· d.						
iding physician and ise as the burial-transit	/Medical								
<u>_</u>	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐Ectopic pregnancy				te of delivery
been signed by the atten should be detached for u	Physician	in the past 12 months? 1 □ Yes 2,□ No	4☐Pregnant a		Other (specify)			M	onth Day Year
by th	hys	9 Unknown							
gned se de	by F	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	inderlying cause give	en in Part I.	1	4	tribute to the cause of death
en si							1 🗆	Yes 212 No	3 Probably 4 Unknown
SS	Completed						24e. Was	DSV	Were autopsy findings avail prior to completion of cause
	EO.						perf-	ormed? 28 No	death? 1 ☐ Yes 2 🖔 No
is certificate director, pag	Be (25. Was case referred to medical examiner?					ath (Check only	one)	
Ø 50	10	1 ☐ Yes 2 No	Hospital: 178 Inpati	ent 2 ER/Outpatier		4 Nuising	Home 5 ☐ Res		
		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o y Year) Injury	Worl	y at k?	28d. Describe	how injury occur	red
or: A	atic	2 Accident investigation			M 1 🗆	Yes 2 No			
Director: In by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	288. Flace Of III	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (Street end Numi wn, State)	ber or Rural Route Number,
e Funeral D letely filled in									
Jy fil	Medical								anner as stated. and due to the cause(s)
F 5	Mec	29b. Signature and title of certifier	* //		29c. Licens	e number		29d. Date signe	d (Month, Day, Year)
o the Fu		11	11.		7) (7)	Ø57329		i /	5/04
To the Funeral Director: After completely filled in by the funer		V. V					I .	1//) / // T
To the Fi		Kerry Kru	W/ W	loath (Item 22c) (To-		Maritan F too too of			3/0/
To the Fi		V		death (Item 23a) (Type,	, Print)		5475 m5.21	OND OF	on A
	to	30. Name and address person who KERRY PEFWITT. 31. Date filed (Month, Day, Year)	M. D. 7	death (Item 23a) (Type, 501 05LEF ar's Signature	, Print)	TOWSON.	MARYL	AND 21	204

			For State Registrar	State of Maryland / D	epartment of Health and l Ce <i>rtificate of Death</i>	Mental Hygien	
Ī	Physici		1. Decedent's Name (First, Middle, Las James Ellsworth R				Oay Year 13, 2004 0011 M
	/Medic Examir		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Deatl		dc. County of Death
			Union Hospital of 5. Social Security Number 6. S		E1kton	8. Date of Birth	Cecil
	Funeral Director			M □ c	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea March 28,	9. Birthplace (State or Foreign Country) 1937 Maryland
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Manyli f sho	tor	Maryland Cecil		h East		1 ☐ Yes 2X No
	or 28a	Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
	ath wi	rail	5 Clearview Avenu		21901		ted States
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Medical Eventral must be redified at ODE.	by Funeral	Marital Status Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	72 hou	eted	15. Decedent's Ec	de completed) /	Decedent's Usual Occupation Give kind of work done during most of work	rkına 16b.	Kind of Business/Industry
2	within ane. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	9	Aircraft
2	Hygie other ent, tr	Be Co	12 17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	
<u>Jan</u>	uld be Vental Irked Itlc ev	To B	James Mulford Rus	sell	Marie E	lizabeth Mu	ırson
lan,	2 sho		19a. Informant's Name/Relationship (Mailing Address (Street and Number or Ru		
ė,	1 and Health em 27 sther t		Karen Carson/Daug 20a. Method of Disposition		of O Irishtown Road, Disposition (Name of crematory or other place)		Maryland 21901 Location - City or Town, State
ē	Pages ent of nt: If It ry or c		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Manioval Ironi State	Janu w Cemetery 200	ary 15,	y View, Maryland
Baltimore,	ppartm portal y inju		21. Signature of Juneral Source Liven	154) 120	22. Name and Address of Facility C		
<u> </u>	825 2 3		Sold &	8			East, Maryland 2190
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Pue to (or as a consequence of	It enter the mode of dying, such as cardiac $)$:	or respiratory arrest,	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate and configurations. Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of Due to (or as a consequence of d.			
_			IF FEMALE:				
P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions c	ontributing to death but not resulting in	he underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Munknown
Division of Vital Records,	ysician: The law r is certificate has be director, page 2 sh	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	ith (Check only one)	
ō	£ 5 m	n: To	1 Yes 25 No 27. Manner of Death	28a. Date of Injury 28b. Til	ne of 28c. Injury at	ome 5 Residence 28d. Describe how inj	
ion	auth. or: After he funera	atio	1 Natural 5 Pending 2 Accident investigation		Work? M 1 Yes 2 No		
Divis	i Sign	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)		City or Town, Sta	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause(rred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
)	To To	Σ	29b. Signature and title of certifier	-0 - 5	29c. License number		Pate signed (Month, Day, Year)
	1		30. Name and address of person who	completed cause of death (Item 23a) (T	U 006061 ype, Print) 223 W m	19 1920 55	1 14 2004
_	7		BARRING 500			P 21921	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 5:10 P.M Laura Mildred Simpson January 12, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood Retirement Center Williamsport Washington If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Months 1□M 2 F 212-38-7479 90 Director May 15, 1913 Maryland Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Funerai Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 16505 Virginia Avenue 21795 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced "naturel" White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Zelouid be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natu any injury or other traumatic avent the second once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Cafeteria 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henry Johnson ဂ Laura Warnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Miller-Daughter 1902 Maplewood Drive, Hagerstown Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State January 17, 4 ☐ Donation 5 ☐ Other (Specify) Laurel Hill Cemetery 2004 Moscow Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McKen Eichhorn-McKenzie Funeral Home P.A. 8 E. Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiag of respiratory about 21539 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** terioscie) disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Compieted by Physician/Medical Examiner Due to (or as a consequence of) **burial-transit** Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 🗷 No 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Pag II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has Nel 1 ☐ Yes 22XN0 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 EN/Outpatient 3 DOA Certification: To this 27. Manner of Death

1/X Natural

2 🗋 Accident 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury af Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number 6 30.-Name and don ss of person who completed cause of death (Item 23a) (Type, Print) Hon Vos 10NO Year) 32. Registrar's Signature 31. Date filed (M State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

o

مٰ

			For State Registrar	State of Ma	ryland / Dep	eartment of Healt eartificate of Dea	isure All Copies th and Mental Hy ath	giene 20	04 02721
	Physici /Medi		1. Decedent's Name (First, Middle, La Ray Edward Spigle	•			2. Date of De Month Januar	Day Y	3. Time of Death 3:23 A
	Examir	ner	4a. Facility Name (If not institution, giv Beverly Healthcar	e		4b. City, Town, or Locat Hagerstown		4c. County of Washin	igton
	Funeral Director		5. Social Security Number 6. S 214-09-5957 Usual Residence of Decedent	OF	(In yrs. last birthday 91 Yrs.) If Under 1 Year If Un Months Days Hou	nder 24 Hrs. 8. Date of Bir urs Min. 01/18/1	rth ay, Yea <i>r)</i> 1912	9. Birthplace (State or Foreign Country) MD
	e-f show	ctor	10a. State 10b. County MD Washing	ton	10c. City, Town or L Hagersto				10d. Inside City Limits 1 📉 Yes 2 🗆 No
	th with the 23a or 28 that be no	Funeral Director	10e. Street and Number 509 Ridge Avenue			10f. Zip Code 21740		10g. Citizen of Wh	at Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Importent: If tiem 27 is marked other then "netural; or Items 23a or 28a-f show any injury or other traumatic event, the Mardical Existinities must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 ☒ No Specify	c Origin? (Specify Yes or No xican, Puerto Rican, etc.) cify:	14. Race - Black, Specify:	American Indian, White, etc. White
1215-0	vithin 72 ho ne. hen "natur e was cal	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	(Give	edent's Usual Occupation e kind of work done during i DO NOT use retired)		16b. Kind of Busin	
Maryland 21215-0036	id be filed v ental Hygie ked other t c event, in	To Be Co	17. Father's Name (First, Middle, Last, Jessie Nichols Sp		1 1	Foundry Worke	er Nother's Name <i>(First, Middl</i> e Ruby Vio1a	, Maiden Sumame)	ng Equip.
	1 and 2 should be Health and Mental ism 27 is marked o other traumatic eve	P	19a. Informant's Name/Relationship (Carolyn Keesecker	Type, Print)			umber or Aural Route Numberry Ct., Hage	er, City or Town, St	
Baltimore,	permit. Pages 1 a Department of He Importent: If item any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif	y)	Rose Hil	nmatory or other place) 1 Cemetery		20c. Location - Ci	
Ba	permit Depar Impor any in		21. Signature of Funeral Service Lice			2. Name and Address of Fa	ac Street, Ha	gerstown,	
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Intra).	Hemorrhage	Tas cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death 20 days
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. Demen					20 days
•	icate be executed physician and s the burial-transit	dicai Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):				
O. Box 6	death certii e attending d for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date o Month	,
rds, P	The law requires that the te has been signed by the sage 2 should be detached.	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	inderlying cause given in Pa			ite to the cause of death? Probably 4XJUnknown
		Completed					24a. Was autor perfo 1 □ Yes	rmed? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
) 	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:		0.1	lace of Death (Check only o		
on or	ing Phy n. After this funeral d	tion; To	1 ☐ Yes 2X No 27. Manner of Death 1 ➢ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	28b. Time o			dence 6 Other ((Specify)
DIVISION	al or Attences after death	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At h <i>om</i> e, farm, sti (Specify)			Street and Number own, State)	or Rural Route Number,
	To the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by	edical	one) 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	xamination and/or in	vestigation, in my opinion, o	e and place, and due to the death occurred at the time, death	date and place, and	due to the cause(s)
	within X To the compl	Σ	29b. Signature and title of certifier Manyer 9.	that		29c. License numb D28365	er :	29d. Date signed (A	
H	U		30. Name and address of person who Manzar Shafi, 368	Mill Stree	t, Hagers		' 40		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Røgistrar	s Signature	well			

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of Ma	aryland /		artment rtificate			and Me		giene Reg. No.	20	n L	02726
	Physicia	an	Decedent's Name (First, Middle, La Thelma K. Schild								Date of Dea Month	ith	12)	(ear	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, T	own, or	Location o		1014 101011	+	County of	Death	0710
	LAGITIII		Washington County	/ Hospital			Haq	erst	own			Was	shin	aton	
	Funeral			ex 7. Age 1 □ M 2 □ 2\$F	e (In yrs. last b	oirthday) Yrs.	If Under 1	Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day	(Year)	9	9. Birthpla Countr	ice (State or Foreign
	Director		204–26–8666 Usual Residence of Decedent		78	115.				μι	aly 2	8 19:	25	Mar	ryland
	show		10a. State 10b. County		10c. City, To	wn or Lo	cation							100	d. Inside City Limits
:	e Mar 3a-f s	ctor	Maryland Washing	gton Co.	Hager	stow	m								1 □ Yes ¾∏ No
	Milh th	Dire	10e. Street and Number				10f. Zip (10g. Citiz	en of Wh	nat Countr	y?
	eath v	Funeral Director	17608 Woodlawn Dr	12. Was Decedent I	Ever in U.S.	13. \		2174		nin? (Specif	v Yas or No-		J.S.A 4 Race	A. Americai	n Indian.
0	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If then Z7 is merked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, If a Madical Examitter must be nutified at once.	by Fun	1 Never Married 2⊠ Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give			fYes, speci 1 □ Yes 2		n, Mexican Specity:	, Puerto Ric	y Yes or No- an, etc.)			white, et Whi	c.
3	atural	ed b	15. Decedent's E	Year or Dates:	16	a. Deced	dent's Usual	Occupa	tion			16b. Kin	d of Busi	ness/Indu	estry
2	an "ng	plet	(Specify only highest gra Elementary/Secondary (0-12)			(Give	kind of work DO NOT use	k done di	urina most	of working					,
7	ed wit ygjene ver tha	Completed	12			Se	creta								ompany
2	be titled High of the officer of the	Be	17. Father's Name (First, Middle, Last)							irst, Middle,				
7	should ind Men s marke umatic	၉	Paul D. Kretzer 19a. Informant's Name/Relationship	Type Print)	10	h Mailir	na Address	(Street a			K. Wis			tate Zin C	Podel
=	and 2 s ealth an n 27 is i	ì	Charles A. Scheld				•								11 C
ע	other		20a. Method of Disposition		20b. Place	of Dispo		e of	1	Date				ity or Tow	
	Pages nent of I ant: If it		tX Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special		St. P				′ I	an. 16	, 2004	4 Cle	ear s	Sprin	ıg, Marylan
	permit. Departr Importa any inji		21. Signature of Funeral Service Lice	nsee	Ù()	13	. Name and	Address Ster	s of Facility	Doug	las A. Hager	Fier	ry Fu	ınera aryl	l Home and 21742
			23a. Part1. Enter the sease, or comshock, or hearthilure. List only	plications that caused one cause on each lir	the death. Do	not ent	er the mode	of dying	, such as	cardiac or re	spiratory arr	est,		1.	Approximate nterval Between
F	hysician	la d	Immediate Cause (Final disease or condition	a FULMI	NAN		J'BR	SIF							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):									1/201
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	e of):				`					104
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	RHEU	man	0 \$	A579	RT	-6/	SEX	2965			de	BCADES
5	e exectan an an urial-tr	Exa	resulting in death) Last	Due to (or as	a consequence	e of):		- 0 .		0:/				4	1500
00/0	cate be executed by sician and the burial-transit	dlcal	•	d. CHRUM	C & B	W/G	rx	3770	-UR	B				Z	BAR
) 	that the death certific led by the attending p detached for use as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							01	2d Data	of dollaron	
	eath atten	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal deal		Ectopic pre Other (spe					2.	Month	of delivery n D	ay Year
į.	t the c by the achec	hysl	9 Unknown	9□ Unknown											
, הם	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions	contributing to death be	ut not resulting	in the ur	nderlying ca	use give	n in Part I.		23e. Did to	P	_	ute to the	cause of death?
	w req	Completed									24a. Was a	ın	24b. We	ere autops	y findings available of
ב	The la te has age 2	dwo									autops perfor 1 ☐ Yes	med?	dea	or to comp ath? Yes 2	
<u> </u>	sician: The law s certificate has b lirector, page 2 s	BeC	25. Was case referred to medical examiner?						26. Place	of Death (C	Check only or	2 No ne)	''	1185 2	
>	Physician: rthis certifica ral director.	To	1 ☐ Yes 2 ☑ No	Hospital: npatie	nt 2 EP/C	Outpatien		-	4 LI NUI	rsing Home	5 🗌 Reside	ence 6	□Other	(Specify)	(208)
	Ing P	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)	ry Year) 28b.	. Time of Injury		Work	?		. Describe h	ow injury	occurred		
2	death death ctor: , the f	licat	Accident investigation 3 ☐ Suicide 6 ☐ Could not be	OB Diago of Init	urv - At home.	farm, str	M eet factory		es 2 D		Location (S	treet and	Number	or Rural F	Route Number,
2	afor after after Dire	Certification:	4 Homicide determined	building, etc	c. (Specify)	,	out, ruotory,				City or Town	n, State)			
	To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Pl	nysician: To the best of miner: On the basis of and manner sta	examination a	ge, death and/or inv	occurred a vestigation,	t the time	e, date and inion, deat	d place, and h occurred	due to the c at the time, d	ause(s) a late and p	and mann place, and	er as stat d due to th	ed. ne cause(s)
	To the within To the complete	Me	29b. Signature and itle of certifier		<u></u>			License				9d. Date	signed (Month, Da	ay, Year)
	_			n	10			(c) (106	02		PAN	11.	3 0	7004
	st 15		30. Name and address of person who	completed cause of d	eath (Item 23a	Jype J	Print)	7 Dec	VVI	on &	or K	CP 1	DEA !	oun	/
ĺ	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	A	arts.	-						V	

	3.		1- For AMENDED ITEM 10 State of Maryland State Registrar WCHD/SH 1/14/2004 per FH		artment of H rtificate of L			ene 2 0	04	02727
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Estilly O Summers	ell			2. Date of Death Month	Day	OH Yeer	3. Time of Death
40.00	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of D	eath	4c. County	of Death	
			12 S. Walnut St., Apt. 810		Hagerst			Was!	hingto	on
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 以 F 71	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of Birth (Month, Day, Sept. 1	^(ear)		ace (State or Foreign ry) Va.
	pue *		Usuel Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	ocation				10	d. Inside City Limits
	d within 72 hours after deeth with the Marylend jiene. r then "naturel", or items 23a or 28s-f ehow the Medical Examinar must be redified at	jō	Maryland Washington H	lagers	town					1X Yes 2 No
	1 the	Director	10e. Street and Number Apt 810		10f. Zip Code		10	g. Citizen of V	What Count	y?
	h witl	<u>=</u>	12 S. Walnut St., Apt. 310		2	21740		U.S.A	Α.	
	deet	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13.	Was Decedent of His	spanic Origin	? (Specify Yes or No- uerto Rican, etc.)		e - America ck, White, e	
90	or its	굨	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▓ No		1 ☐ Yes 2 🖾 No	Specify:	20110 / 110211, 010.7	Specify		ite
8	urel',	d by	3 Wildowed 4 ADIvorced Year or Dates:							
5	n 72	Completed	(Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of	working	6b. Kind of Bu	usiness/Indi	istry
12	iene.	ᄩ	Elementary/Secondary (0-12) College (1-4or 5+) 12 0		Homemak			Her ov	vn hom	ne
Maryland 21215-0036	othe other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle, Ma			
<u>lar</u>	D to D to	ToE	Andrew Mason Byers			Blanc	he McCauley	,		
lan	d 2 should th and Mer 7 ie marke treumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	nd Number o	Rural Route Number, (City or Town,	State, Zip (Code)
	an an an an an an an an an an an an an a		Margaret Keller - Daughter		8 Cearfos					
Ö	ges 1 t of Hi if Iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Dispo netery, crer	sition (Name of matory or other place	9)	Date 20	c. Location -	City or Tow	n, State
ij	t. Partmen tant: vjury				n Cremato					laryland
Baltimore,	permit. Pages 1 Department of H Important: if Ite any injury or ot once.		21. Signature of Funeral Service Licensee	4	15 E.Wils	on Blv	MINNICH FUR d., Hagerst	town, l		L740
Н			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	A 1	^		diac or respiratory arres	it,		Approximate nterval Between Onset and Death
,	Physician	6.9	Immediate Cause (Final disease or condition resulting in death)	Art	ery Dise	ase				Silset and Death
1	/Medical Examiner		Due to (or as a construe	nce of):	allibes	<u>.</u>				
		<u>.</u>	Sequentially list conditions, if any, leeding to immediate b. Due to (or as a conseque	nce of):	evicion	7				
	nted Insit	Examiner	Cause (Disease or injury							
	execu n end ial-tra	Exa	that initiated events c c	nce of):						
Box 68760,	ate be executed hysician end the burial-transit	cai	d							
68	eth certifica ttending phy or use es th									
õ	deeth certifica e attending ph id for use es th	any	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal d		Ectopic pregnancy				e of delivery	
-	B 8 B	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	th 5 ☐	Other (specify)			Moi	nun L	ay Year
P.0	law requires thet the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not result	i n a in the w	nderhing cause gwe	n in Part I	23e Did toba	cco use conti	ribute to the	cause of death?
Division of Vital Records,	uires the signed I Id be det	d by	Congestive heart f	71. [1	I A P		1 ☐ Yes	/	3 🗆 Probal	
Ö	w requ	ete	- Congerage	- W. (L	4 ~		24a. Was an	245.1	Mara autoni	ur findings supulable
Rec	0 - 0	Completed	1				autopsv	ed2	orior to compleath?	sy findings available pletion of cause of
B	an: Th tificate tor, pag	ပိ	25. Was case referred to medical			OO Diseased	performe 1 ☐ Yes 2	Mo 1	☐Yes 2	□ No
5	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Ef	R/Outpatien	ot 3 DOA Othe		Death (Check only one) g Home 5 Lesiden	e 6 ∏Oth	er (Specify)	
o			27. Manner of Death 28a. Date of Injury 2	8b. Time of			28d. Describe how			
<u>ö</u>	Attending I r death. ector: After by the funer	atio	2 Accident investigation	Пушту		es 2 □ No				
<u>V</u> is	i or Attend after death Director: /	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Stre City or Town,		er or Rural i	Poute Number,
Ω	urs afte irai Dir									
	To the Hospitei c within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) One) Certifying Physicien: To the best of my knowl (Check only one) Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or in	n occurred at the time vestigation, in my op	e, date and pl inion, death o	ace, and due to the cau ccurred at the time, date	se(s) and ma e and place, a	nner as stat and due to t	ed. he cause(s)
	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and title of certifler		29c. License			I. Date signed		
	£ ₹ 8		HURCOTT	1 44		607		1/1	1/10	4
	1				Print)	1 / 1	11	1	(0)	
H	(Chad Huberty, MD 2		J. Walnu	yt 5+	Hage.	ston	n, h	D
	Sta Registr		31. Date filed (Month, Pay, Year) 32. Registrar's Signatur	4. A	critar					

		1	For State Registrer	State of Ma	•	ertificate of L			giene Reg. No. 200	4 02728
		_	1. Decedent's Name (First, Middle, Las	it)				2. Date of Dea Month	ath Day Ye	3. Time of Death
	Physicia /Medic		Arlene Joan Sisk					Jan.	12 200	04 3:40 P M
	Examin	_	4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of E	
			Beverly Health Ca	are		Hagerst	own		Washin	
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h y, Ye <i>ar</i>) 9.	Birthplace (State or Foreign Country)
	Director		214-28-0135	□M 21X1F	72 Yrs.	,		09/15/1	1931	PA
	Du >		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or I	ocation				10d. Inside City Limits
	anyla shov	2			•					1 ☑ Yes 2 ☐ No
	Ne M	Director	MD Washing 10e. Street and Number	ton	Hagerst	10f. Zip Code			10g. Citizen of Wha	t Country?
	with t					21740	`		USA	· Country
	eath	eral	750 Dual Highway	12. Was Decedent E	ver in U.S. 13			ecify Yes or No-		American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-f show importent: If item 27 is marked other then "natural", or items 23a or 28e-f show apply injury or other traumatic event, the Medical Examinar must be notified at an once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 梵 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Puerto Specify:	Rican, etc.)		White, etc. White
Maryland 21215-0036	hour Itural	ed t	15. Decedent's Ed		16a. Dec	edent's Usual Occupa	ation		16b. Kind of Busin	ess/Industry
5	n na	Completed	(Specify only highest gra	de completed)	life.	e kind of work done of DO NOT use retired	during most of worki)	ng		
7	iene r the	EO	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Homema	aker		H	ome
ğ	othe ent,	Bec	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
<u>ā</u>	should be f and Mental I s marked of umatic eve	은 B	Donald Raymond R	eigh			Esther	(unk) Ha	ammer	
ary	and N		19a. Informant's Name/Relationship (ling Address (Street a		_		te, Zip Code)
	and 2 ealth a n 27 is		Glendora Brechbi	11/Daughte		0 Lappans				
<u>S</u>	of He		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □	Removal from State	20b. Place of Disp cemetery, cr	position (Name of ematory or other place	θ)	Date	20c. Location - City	y or Town, State
<u>Ĕ</u>	Pages nent of I ent: If its ury or o		' 4 □ Donation 5 □ Other (Specify			irg Cremat			Smithsbur	
Baltimore,	permit. Departr Importe eny inju		21. Signature of Funeral Service Liver	nsee		22. Name and Addres 305 N. Pot				Funeral Home MD 21740
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not e					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lui	es car	respons	ال الله	ph		Onset and Death
	/Medical		resulting in death)	Due to (or as a	a consequence of):		1			
	Examiner		Sequentially list conditions,	b	/	vejas	Tasis			
	p #	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):	2 luch =	2/-21	unLi	0 (1111	2
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Dua to /or as	a consequence of):	crowe c	05711	neg in	2 (1)	7
8760,	cian a	E		Due to for as a	a consequence ory.	disea	20		/	
87	physic the b	dlcal	•	d						
Box 6	eath certifii attending p for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth		Ectopic pregnancy			23d. Date of	f delivery Day Year
o.	requires that the death certificens is a signed by the attending the hould be detached for use as	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			INC.	Duy You.
<u>Д</u>	res that igned b be deta	by Pt	Part II. Other significant conditions of	contributing to death bu	it not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
흔	quire on sig uld b							1/21	es 2□No 3[☐ Probably 4 ☐ Unknown
Records,	aw requii s been s s should	Completed						24a. Was	an 24b. Wer	e autopsy findings available r to completion of cause of
æ	The law ate has b page 2 si	E						perfo	rmed? deat	
Vital		0	25. Was case referred to medical				26. Place of Death	n (Check only o	nne)	
	di is	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2□ER/Outpati	ent 3 DOA Oth	er: 4 Hursing Ho	me 5 Resid	dence 6 Other (Specify)
0			27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injur (Month, Day				28d. Describe h	now injury occurred	
<u>.</u>	Attending r death. sctor: Afte by the fune	atle	2 ☐ Accident investigatio			M 1 🗆	Yes 2 □ No			
Division of	i i i e	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	iry - At home, farm, : c. (Specify)	street, factory, office		28f. Location (S City or Tow		or Rural Route Number,
Ц	Hospitel 24 hours a Funerel I stely filled		29a. Certifier 1 Certifying PI	nysician: To the best of	of my knowledge, de	ath occurred at the tin	ne, date and place,	and due to the	cause(s) and manne	er as stated.
	e Hos 24 h e Fun letely	edical		miner: On the basis of and manner sta	examination and/or					
	To the within 2 To the complet	Me	29b. Signature and title of certifier		ے نے	29c. Licens	e number		29d. Date signed (A	Month, Day, Year)
			1 Dry		+1 ca	DE	10411	37	Janua	Ny 13,2004
H	4-1		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	e, Print)	4 Open	Court	, Itaqe	reform
	Sta	ate	31. Date filed (Month, Pay, Year)	32. Registra	ar's Signature	,		•	ichi	22740
	Regist		JAN 14	2004 Kine	in the	Sperker				

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Beverly Rose Seibert 939 January 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington County Hospital Hagerst or 1 Year Tif Under Washington 7. Age (In yrs. last birthday) 52 If Under 1 Year 8. Date of Birth John Dayo earl 95 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1□M 2XF Hours 216-54-8095 MD Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Exertiner must be notified at MD Washington Clear Spring X□Yes 2□No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with 2 Cumberland St. 21722 U.S.A. or Items 23a by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status □Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 swhite 1 ☐ Yes 2 X No Specify: If Yes, Give 2 Year or Dates: 3 ☐ Widowed 4 ☐ Pivorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Motel/Inn permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) desk clerk years 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson Paul Atherton Reba Ella Mills ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.BOX 213 Clear Spring, MD 21722 Shirley Gossard sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 15,2004 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Big Pool, MD Parkhead Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livins once Donald Edwin Thompson Funeral Home, Inc 2.0.BOX 310 Clear Spring, MD 21722 P.O.BOX Part 1. Enter the diseas shock, or heart ailure isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Dederoli . vosculan deseare Enysician 5 year resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Depend the attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Day 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records. page 2 should be 3 ☐ Probably ♦ ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 ☐ Yes 💸 ☐ No 1 Tyes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 × Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation To the Hospital or Attency within 24 hours after death To the Funaral Diractor: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide pelli 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 283 30. Name and address of person who completed causi f death (Item 23a) (Type, Print) Hergerstown 19 D 2/740 nelle 31. Date filed (Month 32. Registrar's Signature State Registrar

			For State Registrar		State o	f Marylan	id / Dep <i>Ce</i>	artment of H rtificate of L	ealth a Death	and Mer		iene 2	004	02	730
			1. Decedent's Name (Fir	rst, Middle, Las	t)						Date of Deat Month	h Day	Yeer	3. Time of	Death
	Physicia /Medic		Hilda May S	Simmons							nuary		004	6:30	PM^M
	Examin		4a. Facility Name (If not	institution, give	street and nur	mber)		4b. City, Town, or	Location o	of Death	-	4c. Coun	ty of Death		
			Westminster					Westmins				Car	_		
	Funeral		5. Social Security Number		ex □M2DXF	7. Age (In yrs.	-	If Under 1 Year Months Days	If Under :	Min.	Date of Birth (Month, Day,		9. Birthp	lace (State o	r Foreign
	Director		220-24-7713 Usual Residence of Dec	3	X .	75	Yrs.			Ju	1y 31,	1928	Mary	<u>land</u>	
	and and	1		. County		10c. Ci	ty, Town or L	ocation				-	1	0d. Inside Ci	ity Limits
	Mary	ō	MD C	Carroll		We	stmins	ster						1 🗌 Yes	2 🌠 No
	the 28e	Director	10e. Street and Number					10f. Zip Code			1	0g. Citizen o	f What Cour	ntry?	
	3a or	<u></u>	1234 Washin	orton Da	5.00			21157				USA			
	ms 2	Funeral	11. Marital Status	igton K	12. Was Dece	edent Ever in U	.S. 13.	Was Decedent of Hi	spanic Orig	gin? (Specify	Yes or No-	14. Ra	ce - Americ		
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural; or items 23a or 28e-f show event, the Medical Examinar must be notified at event, the Medical Examinar must be notified at	by Fur	1 XNever Married 3 ☐ Widowed 4 ☐		Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 XNo		If Yes, specify Cubar 1 ☐ Yes 2]X ☐ No	n, мехісап Specify:	i, Pueno Rica	an, etc.)		ack, White, <i>ity:</i> Whi		
ŏ	72 hor	Completed	15.	Decedent's Ed	lucation		16a. Dece	dent's Usual Occupa kind of work done d	ation	t of working		16b. Kind of	Business/In	dustry	
21	within 7 ene. than "r	e e	Elementary/Secondary		College (1	1-4or 5+)	life.	DO NOT use retired,)	or working					
7	e filed within al Hygiene. I other then '	S	6				Homer	naker					stic		
pq	d oth	Be (17. Father's Name (First	t, Middle, Last)					18. Mothe	r's Name (Fi	irst, Middle, f	Maiden Suma	ime)		
<u>yla</u>	2 should be tand Mental I is marked or eumatic eve	ဥ	Irvin Handy	Simmor	ıs						Black				
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/				19b. Mail	ng Address (Street a	and Numbe	er or Rural Ro	oute Number	City or Tow	n, State, Zip	Code)	
	and lealth m 27 her tu	1	Richard Sim		cother	205		Douglas S	treet	E1k				Ctata	
O.	ges 1 t of H If ite or ot	- 3	20a. Method of Dispositi 1 X Burial 2 ☐ Cr.		Removal from	State	cemetery, cre	matory`or other place	·			20c. Location	•	JWII, SIAIO	
Ë	. Pa tmen tant: jury		`4 □Donation 5 □			E1		emetery		01/21/	04 _	Elktor	ı, MD		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre once.		21. Signature of Finera	Il Service Licen	104		1	^{2. Name <i>a</i>nd Addres Indrew G. Funeral Ho}	Gee	•		E. Ma			
			23a. Part1. Enter the di shock, or heart fail	isease, or comp	olications that c	caused the dear								Approximat Interval Bet	ween
	Pnysician	K 7	Immediate Cause (Fina disease or condition	al		Seven	e	Dement	161				- 3	Onset and I	
	/Medical		resulting in death)	•	a Due to	(or as a consec		0.4							
	Examiner		Sequentially list condition	ons	b			venia						204	cars
	D ==	ner	cause. Enter Underlying Cause (Disease or injur	dialo	Cua to	(or as a consec	plience of:								
	acute ind trans	Examin	Cause (Disease or injur that initiated events resulting in death) Last	ý	c										
80,	e exection significant		resulting in county case		Due to	(or as a consec	quence or):								
8760,	icate be executed physician and s the burial-transit	dlcal			. d										
9	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	a a	IF FEMALE:		23c If yes out	tcome of pregn	ancv					304.5			
Вох	ath c attend for us	Physiclan/M	23b. Was decedent pre- in the past 12 mgn	nths?	1□Live t	ointh 2 ☐ Feta nant at time of c	al death 3	☐Ectopic pregnancy ☐ Other (specify)				I	ate of delive Ionth	-	rear .
o.	at the de by the a tached	ysic	1 □ Yes 2 ☑No 9 □ Unknown	>	9□ Unkn		leau J								
Δ.	that t ed by detar		Part II. Other significan	nt conditions c	ontributing to d	eath but not res	sulting in the	inderlying cause give	en in Part I.		23e. Did tob	acco use co	ntribute to th	ne cause of d	leath?
Vital Records,	sign sign d be	d by									1 🗆 Y€	s 2 No	3 🗆 Prob	ably 4 🗀	hknown
ŏ	w requir been si should	Completed									24a. Was a	n 24h	Were auto	psy findings	available
Rec	ne lav nhas ge 2	d L								_	autops perforr	y ned?	prior to con death?	mpletion of c	ause of
a			OF Was seen informed to	to enadical						- (D - + + - (C		2 PNo	1 🗆 Yes	2146	
Σ		o Be	25. Was case referred to examiner?	to medical	Hospital:	Inpatient 2	ER/Outpatie	nt 3□ DOA Othe	ar.		heck only on 5 ☐ Reside		h (0if		
of		-	27. Manner of Death		28a. Date	of Injury	28b. Time				. Describe ho			<u> </u>	
o	ding l h. After funer	tior	1 ☑ Natural 5	Pending investigation		th, Day Year)	Injury		k? Yes 2 🔲 I	No					
Division of	or Attending ufter death. Director: After in by the fune	fica	3 ☐ Suicide 6	Could not be	28e. Place			reet, factory, office		28f.	Location (St		nber or Rura	I Route Num	ber,
ā	after d after d Direct d in by	Certification:	4 🗌 Homicide	,	build	ing, etc. (Speci	ty)				City or Towr	i, State)			
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by							th occurred at the tim							`
	n 24 he Fu	Medical	(Check only 2 one)	Medical Exam		asis of examining	ation and/or i	nvestigation, in my op	oinion, dea	un occurred a	at the time, di	ate and place	, and due to	ne cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title	of certifier	Ma			29c. License	number	20	2	9d. Date sign	ed (Month,	Day, Year)	011
) yec	20	1-49			D	510	~>		Jan	16	20	U
			30. Name and address	of person who		and the	m 23a) (Type	Print)		wen	mines	ter 1	49 2	1157	
	Sta	te	31. Date filed (Month, D	111	32. F	Registrar's Sign									
	Registr		31. Date filed (Month, D	2004	Hours.	J.	Sparte	/							

			1 - For Amend Registrer 1. Decedent's Name (aryland / Dep erINFG828 <i>Ce</i>	rtificate of L	Death	Re-		3. Time of Death
	Physici								Month January	Day Yeer	12:27 PM
	/Medic		4a. Facility Name (If n	Y. Scor		<u> </u>	4b. City. Town, or		diludiy .	4c. County of Dea	
	Examin	er		Hospita			Elkton			Cecil	
	Euperol		5. Social Security Nun	-		e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign
	Funeral Director		234-32-275 Usual Residence of D	59 ¹	□ M 25 7 F	79 Yrs.	Months Days	Hours Min.	(Month, Day, October	1, 1924 W	est Virgini
	daryland f show	ō	10a. State MD 1	^{10b. County} (Cecil _	10c. City, Town or Lo	EIKLOH				10d. Inside City Limits 1 Yes 2 No
	28a-	Director	10e. Street and Numb	-1	1 DD	Daciniani	10f. Zip Code		10	g. Citizen of What C	ountry?
	with a sign		3 College	TOO TOO	ırel DR Laurelwood (are Center	26201	- 21921		USA	
	leath	era	11. Marital Status	Avenue	12. Was Decedent I				ecify Yes or No-	14. Race - Am	erican Indian,
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. It is marked other than "natural", or Itams 23e or 28e-f show or other traumatic event, the Medical Eventral restricted rediffical at	by Funerai	1 ☐ Never Married 3 🏋 Widowed 4	_	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	Was Decedent of Hill If Yes, specify Cubar 1 ☐ Yes 2 🏋 No	n, Mexican, Puèrto Specify:	Rican, etc.)	Black, Whi	te, etc. hite
2000	nin 72 hor In "natura Medical B	Completed		5. Decedent's Education only highest gra		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	tion uring most of worki	ng 1	6b. Kind of Business	s/Industry
;	d within giene. ar than "	Eo	12	ary (0 12)	00110ge (1 401 0	Weld	come Wagor	n Coordin	ator	Hospital	ity
	be filed tal Hygi d othar evant, I	Be C	17. Father's Name (Fi	irst, Middle, Last)				18. Mother's Name	(First, Middle, M	aiden Sumame)	
1	should be nd Mental markad o imatic ev	5	Festus Rai	lph Boon	ev Young			Grace L	ance		
	and 2 should the leath and Ment in 27 is marked her traumatic contractions.		19a. Informant's Nam	ne/Relationship (Type, Print)	19b. Maili 163 M 1335	ng Address <i>(Street a</i> larysville Re Elueball	nd Number or Rura 1 North Eas 2000 - 11	t Md 21901 Kton	City or Town, State,	Zip Code)
•	s 1 a f Hea f Hea itam othe		20a. Method of Dispos	sition	_	20b. Place of Dispe				0c. Location - City or	Town, State
	permit. Pages 1 an Department of Heat Important: If item 2 eny injury or other <u>once.</u>		° 4 ☐ Donation 5	Other (Specify		R. A. Fe	rris & Co.	1/14	/04 W	est Chest	er, PA
İ	permit Depar Impor eny in		21. Signature of Fyne	eral Service Licen	Ckoun	Aı	2. Name and Addres ndrew G. (uneral Hor	See		9 E. Main kton, MD	
	Physician /Medical Examiner	ner	shock, or heart Immediate Cause (Fi disease or condition resulting in death) Sequentially list cond if any, leading to immeause. Enter Underly Cause (Disease or in Joseph Cause)	failure. List only inal	a. MYO Due to (or as	the death. Do not enee. CAR DIA a consequence of): a consequence of):		nator	J		Approximate Interval Between Onset and Death HRS. 10 YRS.
	tificate be executed ig physician and as the burial-transit	ledicai Examiner	that initiated events resulting in death) La		c. Pot Due to (or as	a consequence of):	4				3 DAVS
	it the death certif by the attending tached for use a	Physician/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
	The law requires that the ste has been signed by the bage 2 should be detached.	ρ	Part II. Other signific		OLOMYOP		inderlying cause give	n in Part I.	23e. Did toba		o the cause of death?
		Completed							24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	utopsy findings available completion of cause of s 2 \(\text{No} \)
-	Physician: Th this certificate ral director, pag	Be	25. Was case referre examiner?	d to medical	Unanital:		0.15	26. Place of Death			
	S 25	ဥ	1 ☐ Yes 2 ☑ N	0	The second second	nt 2 ER/Outpatie		4 Nursing Ho		nce 6 □Other (Spe	ecity)
	Jing After fune	tlon:	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Inju (Month, Day	y Year) 28b. Time o Injury	Work	at ? ∕es 2 □ No	28d. Describe hov	v injury occurred	
:	I or Attandi after death. Diractor: A I in by the fu	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	tural Route Number,
	To tha Hospitel or At within 24 hours after or To tha Funaral Dirac completely filled in by	edical C				of my knowledge, dea examination and/or in					
	To the I- within 24 To the I- complete	₹	29b. Signature and tit	tle of certifier			29c. License	number	29	d. Date signed (Mon	th, Day, Year)
	F > F 0		mm	ind m.	. Marguy	MD	DO	05662	-	01/13/	2004
	/			s of person who	completed cause of d	eath (Item 23a) (Type			·		
	Sta	ate	31. Date filed (Month)	, Day, Year)		ar's Signature			·		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Day Year Physician January 10. 2004 7:23 AM A.J. Soucy /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Cecil E1kton 145 Red Cedar Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Deys Months Hours 1XM 2□ F Yrs. September 8, 1931 Massachusetts 024-22-9472 Director Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Nem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 1 ☐ Yes 2X No Be Completed by Funeral Director E1kton Ceci1 Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 United States 145 Red Cedar Drive Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Stetus Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married White 1 Yes 2 No Specify: 3altimore, Maryland 21215-0020 Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) Foundation Construction 12 Superintendent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Unknown Alphonse Soucy 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 145 Red Cedar Drive, Elkton, Maryland 21921 Eleanor Soucy/Spouse 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 14, 2004 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Funeral Service Licenses 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical mediate myocardial Examiner Due to (or as a consequence of): Physician/Medical Examiner 6 years duscase (Oronary artery or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physiclan and page 2 should be datached for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significent conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Ischemic Cardingupath Renal Cell Cancer þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Medical Certification: To Be Completed Prostate cancer اللافع Yes 2 1 ☐ Yes 2 ☐ No thypo thyividisa aftar death.

Director: After this cartifice in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Schesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely fillad in by the 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 1/13/04 peashort 000048050 10 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 15 South Parke Street Suite 400 Aberdeen MD 21001 Shukla MO Prashant 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

2004

			For Stata Registrar	State of Ma	•	-	of Health a	nd Mental Hy	giene 20	04 02734
1			Decedent's Name (First, Middle, Last)				2. Date of D	eath	3. Time of Death
	Physici /Medic		GEORGE H	EDRIC	. 14	ST	2000	JAN	17 -	Year 14-18 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Location o	f Death	4c. County of	of Deeth
				MORIALI			AURE D			LCOND
	Funeral		Social Security Number 6. Se	x 7.Ag∉ XIM 2□F	e (In yrs. last birth	day) If Under Months	1 Year If Under 2 Days Hours	Min (Month, D	irth Pay, Year)	Birthplace (State or Foreign Country)
	Director		224-20-1092 Usual Residence of Decedent		80 Y	13.		March	13, 1923	Virginia
	/land		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show I must be notified at	ģ	Maryland Har	ford		Havre de	e Grace			XXYes 2 □ No
	n the	Director	10e. Street and Number			10f. Zip	Code		10g. Citizen of W	hat Country?
	th will	ai	106 Apartment 1,	Bayland D	rive		21078		United	States
	r dea	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Deced If Yes, spec	ent of Hispanic Orig ify Cuban, Mexican,	in? (Specify Yes or N , Puerto Rican, etc.)	lo- 14. Race Black	- American Indian, , White, etc.
96	s afte	by Fi	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	∾ World	1 ☐ Yes 2	No Specify:		Specify:	White
30003	hour litters		15. Decedent's Edu	Year or Dates:	16a. [Decedent's Usua	l Occupation		16b. Kind of Bus	siness/Industry
7	nin 72	piet	(Specify only highest grad	e completed) College (1-4or 5	(Give kind of wor life. DO NOT us	k done during most e retired)	of working		
7	od within giene. ier than "	Completed	07	College (1-40) 5		rklift	Operato	r	Han	bison-Walker_
Õ	othe wart	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Middle	e, Maiden Sumame)
1 5	Menta Menta arked	2	Richard Stroup					Jane Wrig		
9	INICITY ICITION d 2 should be file th and Mental Hy ?? Is marked oth traumatic event		19a. Informant's Name/Relationship (T)		19b.	Mailing Address	(Street and Number	r or Rural Route Num	ber, City or Town, S Ma	aryland, 21078
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	C = W L		Geraldine C. Stro	up/Spouse		6 Apartr Disposition (Nam		ayland Dri		
	Dallimore, bernit, Pages 1 ar Department of Hea mportent: If item sny injury or othe		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ F		cemetery North	Crematory of ol East Me	thodist	January	20c. Location - C	City or Town, State
	t. Pa tmen tment dent:		'4 □Donation 5 □ Other (Specify)	-4	Cemet	ery				st, Maryland
100	Dermi Department Mpoor		21. Signature 1 - uneral Service 2 com			4.0		Crouch Fu		
	- 11		23a. Part1. Enter the disease, or comp	lications that caused	the death. Do no					Maryland 21901 Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lin	ne.		o ay mg, adam da	,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. It	a consequence of					
	Examiner			Due to (or as	a consequence of	1)-				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of	n):				
	cuted nd ransit	Examiner	that initiated events	c						
c	e exercian ar	EX	resulting in death) Last	Due to (or as	a consequence of	f):				
(1)	ate be executed hysician and the burial-transit	licai	(d						
0	is, F.O. BOX 08/1 res that the death certificate igned by the attending phys be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome	of orognopou					
	death c e attend	ian	in the past 12 months?		2 Fetal death	3 ☐Ectopic pro			23d. Date Mon	of delivery th Day Year
\simeq	ched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	time or ceatir	3 🗆 Other (spr				
	that the dectar		Part II. Other significant conditions co	ntributing to death b	ut not resulting in	the underlying ca	ause given in Part I.	23e. Did	tobacco use contri	bute to the cause of death?
76	w requires to been signally be	d by	CHROME OBS	TRUCTIV	E PUL	MONA	RY DISE	ASE IE	Yes 2□No	3 🗖 Probably 4 □Unknown
	law requires that the as been signed by the 2 should be detache	Completed					•	24a. Wa		ere autopsy findings available
0	Te The la te has age 2	E O						per	formed? de	rior to completion of cause of eath? □ Yes 2 2 No
0 3	VICAL ilcian: T certificat rector, pa	BeC	25. Was case referred to medical				26. Place	of Death (Check only		
	nysic nysic nis ce direc	To E	examiner? 1 A Yes 2 □ No	Hospital: 1 🗌 Inpatie	ent 2 DER/Out	patient 3□ DO		rsing Home 5 🗆 Res	sidence 6 Othe	r (Specify)
	ng Phy ng Phy fter this		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Ti y Year) In		8c. Injury at Work?		how injury occurre	d
7 :	SIO teath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 Tes 2 N		/O+	5 /5
ch:	DIVISION I or Attending after death. Director: After	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At home, fari c. (Specify)	m, street, factory	, office	City or To	(Street and Numbe own, State)	r or Rural Route Number,
0 / 5	pitel		29a. Certifier 1 ☐ Certifying Phy	sicien: To the best	of my knowledge.	death occurred :	at the time, date and	d place, and due to the	e cause(s) and man	ner as stated
	UNISION OF VITAL RECORDS, P.Y. To the Hospitel or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detailed.	edical	(Check only 2 Medicel Exem	iner: On the basis o and manner sta	f examination and	or investigation,	in my opinion, deat	h occurred at the time	, date and place, a	nd due to the cause(s)
	To th Forth	Me	29b. Signature and title of certifier				. License number		29d. Date signed	(Month, Day, Year)
			Kunishta	L			02180	9	JAN16	,2004
_	5+ WA		30. Name and address of person who o			Type, Print)				
	STIVH		12 10110			(C ND	limor	M MOIC	D Z109	3
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	-0				
	Regist	ar	JAN 2 0 2004	Blown 1	C. Cons	w				

		State of Ma	aryland / Department of <i>Certificate o</i>		al Hygiene Reg. No. 20	04 02735
	Physician	1. Decedent's Nama (First, Middla, Last) KENNETH NORVAL	SMITH		ata of Death onth Dey	Yaar OOL 3. Time of Death
	/Medical	4a Facility Nama (If not institution, giva street end number)	חובוייט	4b. City, Town, or Location		
4	Examiner		B REHAB	ELXTON	CEC	Ti
	Funeral		a (In vrs. lest birthday) If Under 1 Yas	r If Under 24 Hrs. 8. Da	ata of Birth	Birthplaca (Stata or Foraign Country)
	Director	173-05-2393 1™ 2□ F	86 Yrs. Months Day	s Hours Min. (M	onth, Dey, Year)	Maine
		Usual Rasidenca of Dacedant				
	ahow	10a. Stata 10b. County	10c. City, Town or Location			10d. Inside City Limits
	the Me	Maryland Cecil	North East			1 ☐ Yes 2 XNo
	vith the Me or 28s-1 a be notified Director	10e. Street and Number	10f. Zip Code		10g. Citizan of W	hat Country?
	th wi	168 Mason Lane, Chesapeake	Isle 21	901	Unit	ed States
	72 hours after death with the Merylend natural', or items 23s or 28s-f show dical Examiner must be notified at steed by Funeral Director	11. Marital Status 12. Was Dacadant Armed Forces?	Evar in U,S. 13. Was Dacadant of If Yas, specify Cu	Hispanic Origin? (Specify Y ban, Maxican, Puarto Rican,	as or No- 14. Raca atc.) Black	- Amarican Indian, , White, etc.
9	事る元		No World 1□ Yas 2♥N		Specify:	
8	ural', o		War II			
7	ed within 72 ho ygiene. Per than *natura nt, fra Medical in Completed	15. Decedent's Education (Spacify only highest grada complated)	16e. Decadant's Usual Occ (Giva kind of work don lifa. DO NOT usa reti	upation a during most of working	16b. Kind of Bus	sinass/industry
12	within ene.	Elemantary/Secondary (0-12) Collega (1-4or 5 6	Electrical		F1.	ectric
2	other vent, I	17. Fathar's Nama (First, Middla, Last)	Electrical		t, Middla, Maiden Sumama	
a	antel H ed out			Edna Mae I	Ou wash om	
Maryland 21215-0036	marked marked	John Norval Smith 19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Stre	et and Number or Rural Rout		Stata. Zip Code) 21001
Σ	d2s then 7 le t					h East, Marylar
စ်	Heel Heel	Irene Booth Smith/Spouse 20a. Mathod of Disposition	20b. Placa of Disposition (Nama of cemetery, cramatory or other p	Dat	a 20c. Location - 0	City or Town, Stata
Baltimore,	ages nt of nt of t: if it	1 ☐ Burial 2 【ACramation 3 ☐ Ramoval from Stata		vanue		D 1
늘	it. Portma	4 Donation 5 Othar (Specify) 21. Signature of Funaral Sarvies Uicense	Mayerdale Crem	natory 21, ress of Facility Crouch		k, Delaware
Ba	permit. Pages 1 end 2 should be filed Department of Heelih end Mertel hyg Important: if item 27 is marked othe Important: other treumatic event, and injury or other treumatic event, ance. To Be C	Signature of the state of the s				
		Volet Color				Maryland 21901
	Physician - dical	Part1. Entar tha disaase, or complications that caused shock, or heart failure. List only one ceuse on each list immediate Ceusa (Final		ying, such as caldiac of fasp	matory arrast,	Approximate Intarval Between Onsat and Death
	Examiner	disease or condition resulting in death)	LNUTRITION			
,	 5		Due to (or as e consequanca of):			į
	axecuted an end rial-trensit	b. <u>567</u>	Due to (or es e consequenca of):	אנגנו		
	axecul n end iai-trer	Sequantially list conditions, if any, leading to immadiate causa. Enter Undarkying Ceuse (Disease or injury			7.5415	
38760,	icate be axecuted physicien end s the burial-trensit	Ceuse (Disease or injury	EBROVASCUM Dua to (or as a consequence of):	ALL HEST	DEN2	
•	.9 14 16	resulting in daath) Last	Dua to (or as a consequance or).			
Вох	ndin use use	d				
	deeth e atte ed for	Part II. Other significant conditions contributing to death by	ut not rasulting in the underlying cause	oiven in Part I. 2	3b. Did tobacco use con	tributa to the causa of death?
P.O.	es that the deeth certific gned by the attending p be detached for use es by Physician/Me				1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
	es tha igned be de be de	DEEP VENDU	5 1 M ROM 1805.	L>		/-
Ď	Attending Physician: The lew requires that the deeth certific death. sctor: Atter this certificate has been signed by the attending by the funeral director, page 2 should be detached for use existing the funeral director.	HYPERTENS	STON	2	4a. Was an autopsy parformad?	24b. Were eutopsy findings available prior to
ပ္ထ	The lew require sate has been signed as the page 2 should Completed	HYS LIC IEIO.	71000		F	complation of causa of daath?
æ	The k			Į.	1 ☐ Yas 2 No	1 ☐ Yes 2 ☐ No
Ē	entifica ector, p	25. Was case referred to medical		26. Placa of Death (Che	ck only ona)	
>	yalci is cel dirac	examinar? 1 ☐ Yas 2 No Hospital: 1 ☐ Inpatia	ant 2 ER/Outpatiant 3 DOA	thar: 45 Nursing Home 5	☐ Rasidanca 6 ☐ Otha	r (Specify)
0	g Ph	27. Mannar of Death 1 S Natural 5 Panding 28a. Dete of Inju (Month, De	ry 28b. Tima of 28c. Injury W	ury at 28d. D	escribe how injury occurre	d
<u>.</u>	ath. er: Aff	2 Accident investigation		Tes 2□No		
Division of Vital Records,	tal or Attending Physic is after death. In Director: After this or led in by the funeral director. Certification: To	3 ☐ Suicide 6 ☐ Could not ba dataminad 28a. Placa of Injude building, at	ury - At home, farm, street, factory, offic c. (Spacify)	28f. Lo	cation (Streat and Numba ity or Town, Stete)	r or Rural Routa Numbar,
Ö	rs aft el Di ed in					
	To the Hospital or Attending Physician: The lew require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	29a. Certifier (Check only one) Certifying Physician: To the best of the desired part	examination and/or invastigation, in my			
	vithin o the comple	29b. Signatura and titla of certifier		nsa number	29d. Date signad	(Month, Day, Year)
	F S F O	BL SO MD	D	MOGNICILA	ilal-	1004
	10+1VA	30. Name and addrass of person who complated cause of d	leeth (Itam 23e) (Type, Print)	0060649 23 W MA	12 55	- 004
	104 111.	Ω	OWN MD	ELXTON.	MD 2193	L)
	State		er's Signature	7, 70.0	110	
	Registrar	1011000000	Le donne			

ORIGINAL

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene [] ls Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Year Sanford Barton 6:00AM January 17, 2004 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 7904 Sarakal Road Prince George's Clinton 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 10XM 2□ F Days Months Hours 578 22 9078 Yrs. Director 80 Washington, Sept 5, 1923 Usual Rasidanca of Dacedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Improcraint: if them 27 is marked other than "natural; or items 23s or 28s-f show any Injury or other traumstic event. Its Marilles Essent. 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yas 2 □ No Director Maryland Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7904 Sarakal Road 20735 United States Funeral 11. Marital Status 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian Black, White, etc. 1 Navar Marriad 2 Married 1 Vas 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yas 2√ No Specify: Spacify: Be Completed by White 3 XVidowad 4 □ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Spacify only highest grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) unknown Truck Driver Interstate Van Lines 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) (Unknown) (Unknown) Nellie Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) Edward Sanford (Son) 12629 Lee Way Court, Woodbridge, Va 22192 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1XXBurial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Jan 21, 2004 Suitland, Maryland 21. Signatura of Funeral Sarvice Licensee 22. Name and Addrass of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, Maryland 20735 m0025 28s. Part 1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Death **Physician** Immediata Cause (Final disaasa or condition resulting in daath) /Medical a Arteriosclerotic Coronary Artery Disease Examiner Due to (or as a consequence of): Examine Peripheral Vascular Disease ettending physician end for use es the buriel-transit The lew requires that the death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Myocardial Infarction Physician/Medical Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ cete has been sig , page 2 should b Completed 24b. Were autopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy performed? certificete 1 Tas 2 No 1 ☐ Yas 2 ☐ No Attending Physician: director, Be 25. Was case rafarrad to madical 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 Rasidence 6 Other (Spacify) Certification: To 1 ☐ Yas X X ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 X Natural death. 1 ☐ Yas 2 ☐ No 2 Accident Director: A To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medicai (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) D 27423 Jan. 17, 2004 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Anantha K. Rao, 831 University Blvd East #32, Silver Spring, MD 20903 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 1 2004 Marie Land Registrar

DHMH 16 Rev 6/95

		1 - State Registrar			epartment of H Certificate of I			, No. 2004	02737
Dhusisis	ző.	1. Decedent's Name (First, Middle, I		*			2. Date of Death Month		3. Time of Death
Physicia /Medica	al	DOROTHEA		INEY			10	12. 200	
Examine	er	4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death		4c. County of De	
			ourg Village Nu	Irsing Home	day) If Under 1 Year	Frost If Under 24 Hrs.	burg 8. Date of Birth		Allegany
Funeral Director		220-10-0873	1 □ M 2 💢 F		rs. Months Days	Hours Min.	(Month, Day,) February (irthplace (State or Foreig Country) Maryland
		Usual Residence of Decedent					Tebruary	55, 1715	
e hov	2	10a. State 10b. County	A 17	10c. City, Town	or Location				10d. Inside City Limits 1 Yes 2 □ No
r 28e-f ehow	Director	Maryland 10e. Street and Number	Allegany		10f. Zip Code	Frostburg	100	- Cisina a statut a c	
24 0	2		Kaylor Circle		Toi. Zip Code	21532	100	g, Citizen of What C	
1	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Am	USA lencan Indian,
		1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	ite, etc.
Exa	d b	3 Widowed 4 □ Divorced	Year or Dates					Specify:	White
odice	ete	15. Decedent's (Specify only highest of		(Decedent's Usual Decupa Give kind of work done of ife. DO NOT use retired	luring most of worki	ing 16	6b. Kind of Business	s/Industry
other then ent, the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)		Aid		Nura	ing Home
5	Bec	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, Ma		ing Home
	0		George Kro	oll			M	lary Muir	
o 3	1	19a. Informant's Name/Relationship		19b. I	Mailing Address (Street a	nd Number or Rura	al Route Number, (City or Town, State,	Zip Code)
other tre			an-daughter	20h Place of F	267 Disposition (Name of	6 Pocahontas		burg Md. 215	
50		20a. Method of Disposition 1 Deliberation 2 Programme 3		e cemetery,	crematory or other place	P)	January 16,	c. Location - City or	r Town, State
injury injury B.		 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic 	*	_ Cu	mberland Crema 22. Name and Addres	tory	2004	Cumberla	ind,Maryland
Importent: any injury o once.		1 Jan 5 McKs	0		Eich	horn-McKen		Home P.A. 8	E. Main
	1	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	ed the death. Do no	t enter the mode of dying	such as cardiac o	onaconing N	[d.21539	Approximate
ysician ·		Immediate Cause (Final disease or condition	Aspirati	<i>l</i> . 1	*				Interval Between Onset and Death
edical miner		resulting in death)							1 dayo
miller	- 1		Due to (or as	s a consequence of	morna				4 days
3	_		b	s a consequence of	vateri				4 days
nsit	nlner	Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury	b		vateri				4 days
ial-transit	amin	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to for as	s a consequence of	ration	+			4 days
a in	Examin	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to for as	s a consequence of	ration				4-days
a la	Examin	Sequentially list conditions, if any leading Lammediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as	s a consequence of	ration				4-days
nding physician a use as the burial-	Examin	Sequentially list conditions, and leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	b. Due to for as Due to for as d. 23c. If yes, outcome	s a consequence of s a consequence of s a consequence of general consequency 2 □ Fetal death	ration			23d. Date of de	4-elays
nding physician a use as the burial-	Examin	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as Due to for as d. 23c. If yes, outcome	s a consequence of	rateri	-		23d. Date of de Month	4-days
nding physician a use as the burial-	Pnysician/Medical Examin	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 M No 9 Unknown	b. Due to for as c. Due to for as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	s a consequence of s a consequence of s a consequence of e of pregnancy 2 Fetal death at time of death	3 Ectopic pregnancy 5 Other (specify)	n in Part I.	23e. Did tobac	Month	4 days
gned by the attending physician a be detached for use as the burial-	by Physician/Medical Examin	Sequentially list conditions, and the cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	s a consequence of s a consequence of s a consequence of e of pregnancy 2 Fetal death at time of death	3 Ectopic pregnancy 5 Other (specify)	n in Part I.		Month	4-elays
gned by the attending physician a be detached for use as the burial-	by Physician/Medical Examin	Sequentially list conditions, and the cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome to birth to pregnant a second unknown contributing to death to the pregnant and the pregnant as the pregnant and the pregnant as the pregnant and the pregnant as	s a consequence of s a consequence of s a consequence of e of pregnancy 2 Fetal death at time of death	3 Ectopic pregnancy 5 Other (specify)	n in Part I.	1 Tes	Month cco use contribute to 2 □ No 3 □ Po	days. days. days. days. days. days. days. days. days. days.
s been signed by the attending physician a 2 should be detached for use as the burial-	by Physician/Medical Examin	Sequentially list conditions, and the cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome to birth to pregnant a second unknown contributing to death to the pregnant and the pregnant as the pregnant and the pregnant as the pregnant and the pregnant as	s a consequence of s a consequence of s a consequence of e of pregnancy 2 Fetal death at time of death	3 Ectopic pregnancy 5 Other (specify)	n in Part I.	1 Yes 24a. Was an autopsy performer	Month 2 No 3 P 24b. Were as prior to death?	days. 4-extags o the cause of death? robably 4 (Gunknown utopsy findings available completion of cause of
ss been signed by the attending physician a 2 should be detached for use as the buriat-	Completed by Physician/Medical Examin	Sequentially list conditions, any leading Is announced as cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome to birth to pregnant a second unknown contributing to death to the pregnant and the pregnant as the pregnant and the pregnant as the pregnant and the pregnant as	s a consequence of s a consequence of s a consequence of e of pregnancy 2 Fetal death at time of death	3 Ectopic pregnancy 5 Other (specify)		1 Yes 24a. Was an autopsy performer 1 Yes 2 1	Month 2 No 3 P 24b. Were as prior to death?	days. days. days. days. days. days. days. days. days. days.
as been signed by the attending physician a 2 should be detached for use as the burial-	Be Completed by Physician/Medical Examin	Sequentially list conditions, it any leading to humoridate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 MNo 9 Unknown Part II. Other significant conditions Metabolic Carlotter Conditions Metabolic Carlotter Conditions Metabolic Carlotter Conditions	b. Due to for as c. Due to for as d. 23c. If yes, outcome to birth to pregnant a second unknown contributing to death to the pregnant and the pregnant as the pregnant and the pregnant as the pregnant and the pregnant as	s a consequence of s a consequence of s a consequence of s a consequence of 2 Fetal death at time of death but not resulting in the spath y	3 Ectopic pregnancy 5 Other (specify)	26. Place of Death	1 Yes 24a. Was an autopsy performer 1 Yes 2 (Check only one)	Month 2 No 3 P 24b. Were al prior to death? No 1 Yes	days. 4-extags o the cause of death? robably 4 (Gunknown utopsy findings available completion of cause of
If the this certificate has been signed by the attending physician a uneral director, page 2 should be detached for use as the burian.	To be Completed by Physician/Medical Examin	Sequentially list conditions, any Leading Leading Leading Leading Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown contributing to death 1 PSY CLA	s a consequence of s a consequence of s a consequence of s a consequence of e of pregnancy 2 Fetal death at time of death but not resulting in the	3 □ Ectopic pregnancy 5 □ Other (specify) □ ne underlying cause give	26. Place of Death	1 Yes 24a. Was an autopsy performer 1 Yes 2 (Check only one)	Month 2 No 3 P 24b. Were a prior to death? 1 Yes	days. 4-extags o the cause of death? robably 4 (Gunknown utopsy findings available completion of cause of
After this certificate has been signed by the attending physician a uneral director, page 2 should be detached for use as the burial-	To be Completed by Physician/Medical Examin	Sequentially list conditions, any learning I animal seques. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown contributing to death 1 PS / Class Hospital: 1 Inpati 28a. Date of Injury (Month, Date of Injury	s a consequence of sea consequen	3 Ectopic pregnancy 5 Other (specify) ne underlying cause give atient 3 DOA Dthe ne of 28c. Injury iny M 1 Y	26. Place of Death 4 ID Nursing Homat at 2 es 2 □ No	1 Yes 24a. Was an autopsy performed 1 Yes 2 (Check only one) ne 5 Residence Re	Month 2 No 3 P 24b. Were as prior to death? 1 Yes 26 6 Other (Speinjury occurred	days. 4-extags o the cause of death? robably 4 tounknown utopsy findings available completion of cause of s 2 \(\text{No} \)
Wer this certificate has been signed by the attending physician a uneral director, page 2 should be detached for use as the burial-to-Trible Committee of the Charleston Trible Committee of the Charleston Trible Committee	To be Completed by Physician/Medical Examin	Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome to pregnant a second point of the pregnant and	s a consequence of sea consequen	3 Ectopic pregnancy 5 Other (specify) ne underlying cause give atient 3 DOA Dthe lie of 28c. Injury livy 28c. Injury	26. Place of Death 4 ID Nursing Homat at 2 es 2 □ No	1 Yes 24a. Was an autopsy performed 1 Yes 2 (Check only one) ne 5 Residence Re	Month 2 No 3 P 24b. Were a prior to death? 1 Yes 26 G Other (Speinjury occurred	days. 4-extags o the cause of death? robably 4 (Gunknown utopsy findings available completion of cause of
Wer this certificate has been signed by the attending physician a uneral director, page 2 should be detached for use as the burial-	To be Completed by Physician/Medical Examin	Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome to fine the following to death to form the following to death to form the following to fine the following to fine the following to fine the following th	s a consequence of s a consequen	3 Ectopic pregnancy 5 Other (specify) ne underlying cause give attent 3 DOA Dthe attent 3 DOA Dthe in of 28c. Injury Work 1 Y , street, factory, office	26. Place of Death 4 Inversing Homat at 2 es 2 No	24a. Was an autopsy performed to the control of the	Month 2 No 3 P 24b. Were as prior to death? 1 Yes 26 6 Other (Special Injury occurred	days. 4-extags or the cause of death? robably 4 tounknown utopsy findings available completion of cause of a 2 No actify) ural Route Number,
After this certificate has been signed by the attending physician a uneral director, page 2 should be detached for use as the burial-	To be Completed by Physician/Medical Examin	Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome to fine the following to death to form the following to death to form the following to fine the following to fine the following to fine the following th	s a consequence of s a consequence of s a consequence of s a consequence of e of pregnancy 2 Fetal death at time of death but not resulting in the but not resulting in the but not resulting in the consequence of examination and to f my knowledge, confexamination and the first fi	3 Ectopic pregnancy 5 Other (specify) ne underlying cause give atient 3 DOA Dthe ne of 28c. Injury iny M 1 Y	26. Place of Death 4 Inversing Homat at 2 es 2 No	24a. Was an autopsy performed to the control of the	Month 2 No 3 P 24b. Were as prior to death? 1 Yes 26 6 Other (Special Injury occurred	days. 4-extags or the cause of death? robably 4 tounknown utopsy findings available completion of cause of a 2 No actify) ural Route Number,
Wer this certificate has been signed by the attending physician a uneral director, page 2 should be detached for use as the burial-to-Trible Committee of the Charleston Trible Committee of the Charleston Trible Committee	legical Certification; To be Completed by Physician/Medical Examin	Sequentially list conditions, any learning I animal seques. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome to birth the pregnant and the	s a consequence of s a consequence of s a consequence of s a consequence of e of pregnancy 2 Fetal death at time of death but not resulting in the but not resulting in the but not resulting in the consequence of examination and to f my knowledge, confexamination and the first fi	3 Ectopic pregnancy 5 Other (specify) ne underlying cause give attent 3 DOA Dthe attent 3 DOA Dthe in of 28c. Injury Work 1 Y , street, factory, office	26. Place of Death 4 Wursing Hom at 29 es 2 No 20 e, date and place, a nion, death occurre	24a. Was an autopsy performed 1 Yes 2 (Check only one) ne 5 Residence 28d. Describe how 28f. Location (Stree City or Town, Stand due to the cause dat the time, date 29d.	Month 2 No 3 P 24b. Were a prior to death? 1 Yes 6 Other (Speinjury occurred) at and Number or Rights at and place, and due Date signed (Mont)	days. A ays.
To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial-Madical Continuation To Be Completed by Divisional Madical Continuation To Be Completed by Divisional Madical Continuation Continu	legical Certification; To be Completed by Physician/Medical Examin	Sequentially list conditions, any leading to animal seques. Enter Underlying Cause. Ensease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome to pregnant a general separate and the pregnant a general separate and the pregnant a general separate and the pregnant a general separate and the pregnant a general separate and the pregnant a general separate and the pregnant and the pregnant a general separate and the pregnant and	s a consequence of s a consequence of s a consequence of s a consequence of s a consequence of s a consequence of s a consequence of s a consequence of pregnancy 2 Fetal death at time of death but not resulting in the state of the sequence of examination and/of tated.	atient 3 DOA Dthe Property M 1 York M 1 York Investigation, in my oping 29c. License	26. Place of Death 4 Nursing Hom 27 es 2 No 29 es, date and place, a nion, death occurre	1 Yes 24a. Was an autopsy performed to the cause of the	Month 2 No 3 P 24b. Were an prior to death? 1 Yes 6 Other (Speinjury occurred at and Number or Ristate) Date signed (Mont) Date signed (Mont)	days. 4 ays. 4 ays. 4 ays. 4 ays. 5 the cause of death? 1 robably 4 (gunknown utopsy findings available completion of cause of security) 1 ay Year 1 ays. 1 a
2 should be detached for use as the burial-	medical Certification: 10 be Completed by Physician/Medical Examin	Sequentially list conditions, any leading to animal seques. Enter Underlying Cause. Ensease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to for as c. Due to for as d. 23c. If yes, outcome to pregnant a general separate and the pregnant a general separate and the pregnant a general separate and the pregnant a general separate and the pregnant a general separate and the pregnant a general separate and the pregnant and the pregnant a general separate and the pregnant and	s a consequence of s a consequence of s a consequence of s a consequence of s a consequence of s a consequence of s a consequence of s a consequence of pregnancy 2 Fetal death at time of death but not resulting in the state of the sequence of examination and/of tated.	atient 3 DOA Dithe work investigation, in my opi	26. Place of Death 4 Nursing Hom 27 es 2 No 29 es, date and place, a nion, death occurre	1 Yes 24a. Was an autopsy performed to the cause of the	Month 2 No 3 P 24b. Were an prior to death? 1 Yes 6 Other (Speinjury occurred at and Number or Ristate) Date signed (Mont) Date signed (Mont)	days. 4 ays. 4 ays. 4 ays. 4 ays. 5 the cause of death? 1 robably 4 (gunknown utopsy findings available completion of cause of security) 1 ay Year 1 ays. 1 a

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥎 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Physician 18, 12:48 PM Myrtle Esther Turk January 2004 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Washington Coffman Nursing Home Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | 10/19/1906 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthdey) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F 213-40-3175 97 Yrs Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours effer death with the Meryland of Health and Mentel Hygiene.
Item 27 is marked other than "natural", or frems 23s or 28s-f show other traumatic event, the Medical Examiner main be notified. 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 No 2 No Funeral Director Washington Hagerstown 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code United States 21742 1304 Pennsylvania Ave. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2V No If Yes, Give 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specity: White Completed by 3 Widowed 4 □ Divorced Year or Dates: 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Ernest Knight Margaret Esther Knight Peges 1 end 2 should 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Astrid E. Cavin/Friend 19637 Marigold Drive, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Department of I important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/21/04 Rest Haven Cemetery Hagerstown, MD 4 Donation 5 Other (Specity) 22. Name and Address of Facility Gerald N.Minnich Funeral Home 21. Signature of Funeral Service Licenses BU5 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each fine. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner inding physician end use es the burial-trensit To the Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Be Completed by 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4 Medical Certification: To 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 28d. Describe how injury occurred 27, Manner of Dueth 28e. Date of Injury (Month, Dey Year) 28b. Time of After 1 Platural 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth 2 ☐ Accident in by the within 24 hours efter deeth To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 665 completed ceuse of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year) JAN 2

Registrar's Signature

			1 - For Stete Registrar	State of	Maryla	nd / Depa	artmen rtificat					giene ,	2004	02730
			1. Decedent's Name (First, Middle, Las	t)							2. Date of De	ath		3. Time of Death
	Physic: /Medi		Bertha Rae Tress	ler							Janua	Day	Year 700LL	0038 M
8	Examir		4a. Fecility Name (If not institution, give	street and num	ber)		4b. City,	Town, or	Location o	of Death			unty of Death	
			Washington County		al				town			W	ashing	ton
Ŋ.	Funeral		5. Social Security Number 6. Se	ex □M 2.Σ(F	7. Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Dete of Birt (Month, Da	y, Year)	Cour	
6.2	Director		527-44-2317	-77		66 Yrs.					Decemb	er 20	,1937 A	rizona
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	ocation		-				1	10d. Inside City Limits
	Many -1 • th	ţ	Maryland Washing	ton	H	agersto	w							1 X Yes 2 □ No
	h the	Director	10e. Street and Number			agoroco	10f. Zip	Code				10g. Citizen	of What Cour	ntry?
	th with 23a o	ai D	713 Florida Avenu	e			2	1740				USA		
	ems erm	Funeral	11. Marital Status	12. Was Deced	dent Ever in U	U.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	city Yes or No	14.	Race - Americ	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, Give	2 X No	ŀ	1 ☐ Yes 2		Specify:	, 1 00110 1	nouri, otc./	So	Black, White, ecity: Whi	
Ö	hours ture (d b	3 Widowed 4 Divorced	Year or Da	tes:									
21215-0036	within 72 hours after death with the Maryland ene. then 'naturel', or items 23e or 28e-f ehow its Mailcel Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		16a. Deced	dent's Usua kind of wor DO NOT us	k done d	uring most	of working	ig .	16b. Kind	of Business/In-	dustry
712	with iene.	mo	Elementary/Secondary (0-12)	College (1-	4or 5+)	Dock						Date:		
b	a filled I Hyg othe	Bec	17. Father's Name (First, Middle, Last)			DOCK	Duper	V 150		r's Name	(First, Middle,	Roto Maiden Sur		
Maryland	uld be Aenta rked tlc ev	ToB	Daniel Charles	Cravey					Eve	1 vn	Alice 1	Rivler		
an	and N	,	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a			Route Numbe			Code)
	and and in 27		George E. Tressler	/Husbar		713 F	lorid	a Av	enue,	Hag	erstown	n, Md.	2174	0
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23s or 28s-f ehow any injury or other treumatic event, the Moutcal Examiner must be notified at ODGE.		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ I	Removal from S		Place of Dispo cemetery, cren	sition (Nam natory or of	ne of ther place)	Da	ate	20c. Locati	ion - City or To	wn, Stete
Ë	Ement tant: jury		*4 □ Donation 5 □ Other (Specify)		ithsbur	g Cre	mato	ry 1	./14/	2004	Smith	sburg.	Maryland
Bal	Depar Depar Impor Impor		21. Signature of Funeral Service Licens			22	. Name and	d Addres	s of Facility	Res	t Haver	Fune	ral Ch	apel .
	101140		23a. Part1. Enter the disease, or comp	IV		1	601 P	enns	ylvan	ıia A	venue,	Hager	stown,	Md. 21742
ji la	Physician		Immediate Cause (Final disease or condition	ne cause on ea	Cardi	ec /			lio.		respiratory an	est,		Approximate Interval Between Onset and Death
N.S	/Medical Examiner		resulting in death)	Due to (o	ras a consec	quence of):		/ -	-		-			
Ь		-	Suggestially list conditions	b. Due to to	r a consec	rdial	dr.	forc	lio	m				
	uted J Ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	D	abet	T	11011.	tu						
ó	exec in an	Exa	resulting in death) Last	Due to (o	r as a consec	quence of):	, accord	20003						
8760,	icate be executed physician and s the burial-transit	dlcai		d										
9	ng ph	Med	IF FEMALE:											
Вох	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregn		Ectopic pre	onancy				23d.	Date of delive	
	res that the death igned by the atte be detached for	sici	1 Yes 2 No	4☐Pregnar 9☐ Unknov	nt at time of o		Other (spe						Month	Day Year
P.0	hat the	P _P	Part II. Other significant conditions co	ntributing to dog	th but not con	sulting in the co			e in De al		00- Dida-			44.40
Records,	signe d be o		End of the	la a	dine.	suiting in the tin	ioeriying ca	use giver	in Parti.			paccousero es 2□No		e cause of death?
Ö	w require been sig should b	etec		ic jan	C-u									abiy 4 igonknown
Rec	has ge 2:	Completed									24a. Was a autops	iy	b. Were autor prior to con death?	osy findings available inpletion of cause of
		မ Co	25. Was case referred to medical									2 X No		2 No
Vital	ysician: Is cartific director.	o B	examiner?	Hospital: 1 ☐ Inp	national OF	ER/Outpatient		Other			Check only on			
ō	g Phys er this eral di	F 1	27. Manner of Death	28a. Date of	Injury	28b. Time of		c. Injury : Work?	4 Nurs		e 5 Reside)
0	ttending f death. ctor: Atter y the funer	atio	17 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month,	Day Year)	Injury	М		os 2∐N			,,		
Division of	er de er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place o	Injury - At h	ome, farm, stre fy)	et, factory,	office		28	If. Location (St	reet and Nu	mber or Aural	Route Number,
	spital or ours aftr neral Dir filled in	Cer		00.10119							City or Town	i, Siare)		
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exami	ner; On the bas	is of examina	owledge, death ation and/or inv	occurred a estigation, i	t the time	, date and nion, death	place, an	d due to the ca	ause(s) and	manner as sta	ated.
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier /	and manne	r stated.			License						
)			Daniel 1-	uliva.	1.		250.			416	2	/ / /(ned (Month, D LI/) V	vay, rear;
	8	-	30. Name and address of person who co	ompleted cause	of death (Item	n 23a\ (Tupo 5	Print)	<i>)</i> d	023	5		/	10/	
3	X Y		Dr. Bapura	12	31	Oak 1	fiel "	4.00	/.	Lin	ad	217	4)	
	Sta		31. Date filed (Month, Day, Year)	32. Rec	istrar's Signa	ature	1 1	IV	- 1	1	1.0	0 / (1 4	
Ĉ.	Registra	ar	OHIV TO 7	UU4	Meur	10. 16%	mar							

ORIGINAL

	Physic		Registrar 1. Decedent's Name (First, Middle, Last	st)		ertifica	ate of	Death	2. Date of De			3. Time of Death
	/Medi		Nellie May Thomas	S					Month O1	12	2004	3:35 a ^M
	Exami		4a. Fecility Name (If not institution, give	e street and number)				or Location of Deat	h		County of Death	
			Homewood Retireme		// t bib-/		liams	1	B Date of B		shingto	
	Funeral Director		5. Social Security Number 6. S 214-09-4224 Usuel Residence of Decedent	ON ADE	(In yrs. last birthda)5 Yrs.	Month				1908	Got Cot	pplace (State or Foreign untry) PA
	yland how		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
	th with the Marylar 23a or 28e-f show	Director	MD Washing	ton	Hagersto					10 000	()	1∏ Yes 2 □ No
	with the or 2	Dir	10e. Street and Number 1136 Luther Drive	•		101.	Zip Code 2174(n		US	en of What Cou	untry?
	ier death Items 23	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S. 13	3. Was De		Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No		4. Race - Amer	
SAM	9 ta 5	þ	1 ☐ Never Married 2 ☐ Marned 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			pecify Cub 2 1 No		to Rican, etc.)		Black, White	hite
35		Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dec (Gi	edent's U	sual Occur work done	pation during most of wo id)	rking	16b. Kin	d of Business/l	ndustry
3	d 2121 filled within Hygiene. ther then "	ошо	Elementary/Secondary (0-12)	College (1-4or 5+	-)	itter		ia)		Clo	thing N	Manufacturer
		Be Co	17. Father's Name (First, Middle, Last)		10.2			18. Mother's Na	me (First, Middle			
	Taryland 212: 2 should be filed within and Mental Hygiene. is marked other than aumatic event, Italia	To B	William Russell 1	Kiser				Grace N	May Bell	e Lit	tle	
104	May that trau		19a. Informant's Name/Relationship (19a) Wayne E. Kiser /		1			and Number or Rid, Willia				îp Code)
3	of Hei		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dis	position (frematory o	Name of or other pla	се)	Date	20c. Loc	ation - City or 1	Fown, State
	limor Pages Iment of tent: If it jury or o		* 4 ☐ Donation 5 ☐ Other (Specify	y)	Rest Hav	zen C	emete	ery 01/1	5/2004	Hager	cstown,	MD
	Baltimore, I permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Signature of Funeral Service Licen	1500								meral Home
	3 2 7 1		23a. Pert 1. Enter the disease, or comp	plications that caused t	the death. Do not e			tomac Str			own, M	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition		s vascul		- 22	ident				Interval Between Onset and Death
S	/Medical		resulting in death)	u.	consequence of):	0,1	مدرد	raent				Jacys
Swwo	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):							
Tho.	d d ansit	Examiner	Cause Disease or mury		consequence or,							
1	760, be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a	consequence of):						-	
	6876 tificate be tig physicia as the bu	lical		d.								
	X 68	/Mec	IF FEMALE:	23c. If yes, outcome o	t pregnancy						d Bara das	
Vellie	vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate sr death. ector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the	by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	B □Ectopic B □ Other	pregnancy (specify)	у		23	d. Date of deliving Month	Day Year
	IS, P	y P	Part II. Other significant conditions of	ontributing to death but	t not resulting in the	underlyin	g cause gr	ven in Part I.	23e. Did	obacco us	e contribute to	the cause of death?
	cords	ted	congestive h	eart fail	ure				1 🗆	Yes 2 ☑	rKio 3∏Pro	bably 4 Unknown
	law r law r las be	Completed	diabetes me	llitus					24a. Was	an	24b. Were aut	opsy findings available ompletion of cause of
	Vital Rec								1 🗆 Yes	2 No	death? 1 🗌 Yes	2 No
	Vita sician: certific irector,	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	t 2 ER/Outpati	ient 3	DOA Oth		ath <i>(Check only i</i> Iome 5 ☐ Resi		D015 (0	
	g Physer this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time	of	28c. Injur		28d. Describe			iry)
	sion (anding F ath. or: After	atio	1 Matural 5 Pending 2 Accident investigation	1	Year) Injun	М		Yes 2 □No				
	Division of Vital Records, lat or Attending Physician: The law requires to safter death. I Director: After this certificate has been signed in by the funeral director, page 2 should be come.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm, (Specify)	street, fact	lory, office		28f. Location (City or To	Street and wn, State)	Number or Rur	ral Route Number,
	DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it	Medical (29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exam	ysician: To the best of niner: On the basis of a and manner state	examination and/or	ath occurre investigati	ed at the til	me, date and place opinion, death occu	a, and due to the urred at the time,	cause(s) a date and p	nd manner as : lace, and due !	stated. to the cause(s)
	To the within 2 To tha complet	×	29b. Signature and title of certifier		٨	2	29c. Licens				signed (Month,	
			Cynthia Ku		•			7451			ary 12,	
	JH.V		30. Name and address of person who cay n+h, a Kuttner-Sa	completed cause of de	ath (Item 23a) (Typ + 214 Pource	e, Print)	Chai	nch Road,	Hagers	nwot:	Mar	yland
		ate	31. Date filed (Month, Qay, Year)		's Signature					7 7 8		

Baltimore	
C	
O. Box 68760,	
Records, P.(

JAMES TURNER

			1 - For State Registrar	State of Mai		artment rtificate					Reg. No. 2	004	0274	
	Physici		Decedent's Name (First, Middle, Last, JAMES MELVIN TURNI							JANUAF		2004	3. Time of Death 10:32 P M	
	/Medic Examir		4e. Fecility Name (If not institution, give ST. MARY S HOSPITA	street and number)		LEON	[ARD]				ST. N	ty of Death		
0.	Funeral Director		210 34 37/1	344 0005	(In yrs. last birthday) 73 Yrs.	If Under Months	Days	If Under: Hours	Min	8. Date of Birth (Month Day Year) NOVEMBER 30,1950 9. Birthplace (State or Foreign MARYLAND)				
	e Maryland Ba-f show	Director	Usual Residence of Decedent		10c. City, Town or Lo		E						0d. Inside City Limits 1 ☐ Yes 2 No	
	s with the		10e. Street and Number 28400 THOMPSON COI	RNER ROAD		10f. Zip	Code 20659)			10g. Citizen o			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or Itama 23a or 28a-f show int, the Medical Examinat must be notified at	ed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2	No I Occupa	Specify:		ecify Yes or N Rican, etc.)	Spec	DLA	etc. .CK	
21215		Completed	(Specify only highest grade Elementary/Secondary (0-12) 12TH GRADE	e completed) College (1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired)	luring most)	t of worki	ng	PAINT	ING IN	DUSTRY	
land ;	B la b	To Be Co	17. Father's Name (First, Middle, Last) WILLIAM AUGUSTINE	HILTON	,						JRNER YA			
Maryland	d 2 sh th and th and 7 is m traum		19a. Informant's Name/Relationship (Ty MARY TURNER YATES								OBURG, N			
Baltimore,	oth H		20a. Method of Disposition 1	lemoval from State	20b. Place of Dispo cemetery, crer MARYLAND	natory or ot	her place			oate 22, 2004	20c. Location			
Balti	permit. Page Department of Important: If any injury or once.		21. Sture of Funeral Service Licens LXDIA C. THORNION J	CHINSON MOOSE		Name and	Addres	s of Facility	OME, 1	P.A.	D, MARYL		640	
8760,	Physician /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) 5-quientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of): consequence of): consequence of):			7.		-	arrest,	<i>L</i> .	Approximate Interval Between Onset and Death Market Acry and Lay	
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tii 9⊡ Unknown	Fetal death 3	∃Ectopic pre ∃ Other (spe						ate of delive	ory Day Year	
α.	quires that n signed b ald be deta	by	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying ca	use give	n in Part I.		111	tobacco use co		ne cause of death? ably 4 □Unknown	
Vital Records,		Completed								24a. Was auto perfo 1 - Yes		prior to con death?	psy findings available inpletion of cause of 2 No	
Vita	Physician: T r this certificat ral director, pa	o Be (25. Was case referred to medical examiner?	fospital:	• C 5000		. Othe			(Check only	_			
of	ge fte	-	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time of		Bc. Injury Work	at ? ′es 2 ☐ l	2		idence 6 🗆 Othow injury occu		9	
Division	sal or Attending s after death. I Director: After ad in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory,	, office		1	28f. Location (City or To	(Street and Num wn, State)	nber or Rura	l Route Number,	
	To the Hospital or I within 24 hours after To the Funeral Directorpletely filled in D	Medical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exemi	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) and n date and place	nanner as st. , and due to	ated. the cause(s)	
•	To the To the comp	M	29b. Signature and title of certifier SCGaby	M.I) ,		License	number 543 (46		29d. Date sign		Day, Year)	
1	B251		30. Name and address of person who co CHANDRA SAJJA MD	PHILIP BE	AN HOLLYWO	OD. Md	206	536						
16	Sta Registi		31. Date filed (Month, Pay Year) 1 2	32. Redistrar	s Signature	barte	9							

		riedse i		Department of Health of	•	
		For State Registrar	State of Maryland /	Department of Health as Certificate of Death		_ ZUHL 11276
	1,5%	Decedent's Name (First, Middle, Last)		- Commodity of Bodin	2. Date of Death	. No. 3. Time of Death
Physicia		Miner	L. Vai	1 Jr.	Month	Day 7 2004 2029 M
/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of		4c. County of Death
		Chester River H	ospital Cent	er Chesterto	Wh	Kent
Funeral		5. Social Security Number 6. Sex	7. Åge (In yrs. last b	Months Days Hours	Min. (Month, Day, Y	9. Birthplace (State or Foreign Country)
Director		168-24-6703 Usual Residence of Decedent	/1	Yrs.	August 13,	1932 Paoli, PA
land ow		10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits
Mary Feb	to	Maryland Kent	Ro	cKhall		1 ☐ Yes 2 XNo
h the	lrec	10e. Street and Number		10f. Zip Code	10g	Citizen of What Country?
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show he Medical Examiner right be notified at	Completed by Funeral Director	6008 Hynson Ro	ad	21661	L U	inited States
r dea	ner		Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36 safte	y F.	1 ☐ Never Married 2 🔀 Marned 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	, ,	Specify: White
hour hour	ed b	15. Decedent's Educ	Year or Dates:	a. Decedent's Usual Occupation	101	
in 72	piet	(Specify only highest grade	completed)	(Give kind of work done during most of life. DO NOT use retired)	of working	b. Kind of Business/Industry
id 21215-0036 filed within 72 hours aff Hygiene. Other than "natural", or ent, the Medical Express	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Chairman		dustrial Supply Co.
be filed tal Hygied d other	Bec	17. Father's Name (First, Middle, Last)	M: T 17-:	18. Mother's	s Name (First, Middle, Mai	den Sumame)
Maryland d 2 should be file th and Mental Hy it Is marked oth traumatic event	To I		Miner L. Vai	i, Sr. Milo	lred Brooke	2
2 sho and lam		19a. Informant's Name/Relationship (Typ		b. Mailing Address (Street and Number		
e, N 1 and Health em 27 ther tr		William Vail				Malvern, PA 19355
		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re	emoval from State	of Disposition (Name of ary, crematory or other place)		c. Location - City or Town, State
F 2 5 2 5	1	*4 □Donation 5 □Other (Specify)	,			Philadelphia, PA 19136
Balti permit. Departi Importe eny inju		21. Signature of Funeral Service License	· /	22. Name and Address of Facility Beeson Memorial	Services	
a hadda a	-	23a. Part 1. Enter the disease, or domplie	ations that caused the death. Do	412 Philadelphia	<u>Pike Wilmin</u>	agton DE Approximate
		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		iruiac or respiratory arrest,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	udiac Death		Smin
Examiner			DasylaidHam	a including Chro	nic Atual 4	Ch. Intro
2 - 3	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):	TIC PITULES 1	IOVITATION
cuted	Examiner	that initiated events				
		resulting in death) Last	Due to (or as a consequence	of):		
876 ate b	Cal	d				
Records, P.O. Box 687(The law requires that the death certificate to the has been signed by the attending physic page 2 should be detached for use as the to the total street in the tota	Physician/Med	IF FEMALE:			- 01	
Box auth cert attendin for use	an	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death			23d. Date of delivery Month Day Year
O. the de trhe de trhed trhed	ysic	1 Yes 2 No	4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month Day 10a
15, P.O. res that the de signed by the abedetached to		Part II. Other significant conditions conf	ributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
Vital Records, sicien: The law requires t certificate has been signe rector, page 2 should be e	Completed by	HTIU; Mitval Rea			1 ☐ Yes	2 No 3 Probably 4 Unknown
w require	ete	overweight; +		, , , , ,	24a. Was an	24b. Were autopsy findings available
Rec	Ē		1. (0.0.) (1.0.3		autopsy performed	prior to completion of cause of death?
	0	25. Was case referred to medical		26 Place of	1 ☐ Yes 2 🗗	No 1 Yes 2 No
f VI	LOB	examiner?	ospital: 1 Inpatient 2 ER/O	Other	ng Home 5□ Residence	6 □Other (Specify)
n of ng Phys ter this neral di		27. Manner of Death 1. ■ Natural 5 □ Pending		Time of 28c. Injury at Injury Work?	28d. Describe how in	
Division Lor Attending after death. Director: After Lin by the fune	Sati	2 ☐ Accident investigation		M 1 Yes 2 No		
Division c alor Attending P atter death. I Director: Attert d in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, rate)
		20a Cartilas (D.A. V.)	T. A. A.			
Hose 24 ho Fund Stely f	Medical	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	er: On the basis of examination at	e, death occurred at the time, date and pad/or investigation, in my opinion, death	place, and due to the cause occurred at the time, date :	e(s) and manner as stated. and place, and due to the cause(s)
o the ithin o the smple	Μe	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
+ 3 + ŏ		10000	assil			1
-1		30. Name and address of person who con	noleted cause of death (Item 22a)	(Type Print)	//	11/04 40 21620:
50		WeilStodday		Brown St. Ches	textown 1	40 21620.
Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4		1 - 4
Registra	r	JAN 1 4 20	04 Marie D	Society		

			1 - For State Registrar	State of Maryla	nd / Dep	artm		ealth an	d Mental F		2004	02744
	Physici	an.	1. Decedent's Name (First, Middle, Last)		_				2. Date of Month			3. Time of Death
	/Media	cal	Norma Jean Wilhe			T	v. -		01	13	3 04	11:32 A.M
	Examir	ier	4a. Facility Name (If not institution, give s SACTED NEAR+			460	ity, Town, or	P AAA	eath	/	County of Deet	
	Funeral		5. Social Security Number 6. Sex	7. Age /In vrs	. last birthday,		der 1 Year	If Under 24	drs. 8. Date of	Birth	G Ried	hplace (State or Foreign
-à	Director		103 34 0733	M 20 F 60	Yrs.	Mont	hs Days	Hours N	1 9-5-1	Day, Year, 943	MD°	uintry)
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation						10d. Inside City Limits
	Mary In sh	tor	MD Allegany	C	umberl	and						1 ∑Yes 2 No
	or 28s	lrec	10e. Street and Number			10f.	Zip Code			10g.,Ci	tizen of What Co	untry?
	ath w	raf	Seton Drive Ext.				1502			USA		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or item 238 or 28s-f show other traumatic event, the Medical Exeminational be notified at	by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	 12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 			scedent of Hispecify Cuba s 2 No	spanic Origin' n, Mexican, Pi Specify:	(Specify Yes or uerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Wh	e, etc.
21215-0036	hin 72 ho In natur Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Dece (Give	edent's L kind of DO NO	Isual Occupa work done d Tuse retired,	tion uring most of	working	16b. K	and of Business/l	ndustry
21	ed with	Com	12	College (1-401 3+)	Cas	s ewo	rker			Pul	plic wel	fare ser.
Maryland	htal H	Be	17. Father's Name (First, Middle, Last) Reggie Henry Wil	halm					Name (First, Midd	lle, Maider	Sumame)	o .
Ž	should be in and Mental I is marked of umatic even	2	19a. Informant's Name/Relationship (Tvi		19b Maili	ina Addr	ess (Street a		Marie Lo Rural Route Nun	<u> </u>		in Codo)
	nd 2 : alth ar 27 is or trau		Alice Bryant, fr	, ,					an, PA	15545		ip Code)
Baltimore,	of Hear		20a. Method of Disposition 1 Disposition 3 DR	20b.	Place of Dispo cemetery, crea				Date	20c. L	ocation - City or 1	Town, State
Ĕ	Pages tment of I tant: If its		'4 □ Donation □ Other (Specify)	Mi				- 1	1-16-04	Bu	Kalo Mi	lls. PA
Bai	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Furieral Service Lin-Inse				and Addres	,	. <i>t</i>	0 11		
po.			23a. Part 1. Enter the disease, or composhock, or heart failure. List only of	cations that caused the dea	th. Do not ent	ter the m	ey n.	Leighe	r Funera	Arrest.	ie, Hyndi	Man, PA Approximate
	Pnysician _i	n d	shock, or heart failure. List only of Immediate Cause (Final disease or condition	1								Interval Between Onset and Death
15	/Medical		resulting in death)	Due to (or as a consec	quence of):	-1 ()	TOUR	WITE	1731646	- UY II	-UNC110-	1 WEEK
	Examiner	<u>.</u>	Sequentially list conditions, b	CORCUALLY Due to (or as a consec	ALTEN	0	13617	E				YIEARS
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	DIAGERES								N/4 5
oʻ	ate be executed nysicien and he burial-transit		that initiated events cresulting in death) Last	Due to (or as a consec	quence of):	714	2	yp - 2				YRS
3/60,		ical	d									
RO X	leath certifica attending ph	Physician/Med	IF FEMALE:				-			-		
gox	attene I for us	cian	in the past 12 months?	Ic. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	uldeath 3□		pregnancy (specify)				23d. Date of delive Month	rery Day Year
j.	at the de by the a	hysi	1	9□ Unknown			(4,500)/					
ς, J	gned be de	by P	Part II. Other significant conditions con		sulting in the u	nderlyin	g cause give	n in Part I.	23e. Dio	tobacco L	ise contribute to	the cause of death?
D O	w requir been si should	eted	Acure RENOR 1						- 1	Yes 2	No 3 Pro	bably 4 Unknown
Hecord	of O O	Completed	CHONTE MENTZ		~ · · · ·			-	24a. Wa	s an opsy formed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
-00		e Co	MORBIO 03ET	X11.7				06 Place of F	1 ☐ Yes	2 No		2 □ No
<u> </u>	× .0 0	To B	examiner?	ospital: 1 Inpatient 2	ER/Outpatien	nt 3 🗆	Other		eath (Check only Home 5 Re		6 □Other (Speci	fv)
			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f	28c. Injury Work	at	28d. Describe			
DIVISION	Attending r death. ector: Alter by the fune	Icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h		M		es 2 □No	2001	10.		
	afor A after f Direction by	Certification:	4 Homicide determined	building, etc. (Special	y)	eet, ract	огу, опісе		City or T	own, State	a Number or Hur.)	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Cartifying	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death	h occurre vestigati	ed at the time on, in my opi	o, date and pla nion, death oc	ice, and due to the curred at the time	e cause(s) o, date and	and manner as s place, and due t	stated. o the cause(s)
	To th within To the compl	₩	29b. Signature and title of certifier	7 11		2	29c. License	number		29d. Dat	e signed (Month,	Day, Year)
•	2		July -	Jullen	_		D 4:	2054		01	/13/20	04
J	no		30. Name and address of person who cor	npleted cause of death (Iter	n 23a) (Type,	Print)						
	// Ø/ ≫ Sta		31. Date filed (Month, Day, Year)	SON 912 32 Registrar's Signa	Jeton	UR		umber	Plands	10	21562	
	Registra		JAN 1 5 2004	ha	19	So	als					

			4 17	epartment of Health and Mental Hy Certificate of Death	ygiene ₂ 004 02745
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of D Month	leath 3. Time of Death
	/Medic Examir	cal	Dorothy Wikoff Wade 4a. Fecility Name (If not institution, give street and number)	Janua: 4b. City, Town, or Location of Death	a di a di a di a di a di a di a di a di
			Calvert Manor Healthcare Center	Rising Sun	Cecil
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min (Month C	lay Year) Country
	Director		Usual Residence of Decedent	Novembe	er 5, 1914 Illinois
	yiend ***		10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	Me.	햟	Maryland Cecil North	East	1 ☐ Yes 2XXVo
	or 28	Directo	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	72 hours effer deeth with the Meryland neturel', or Iteme 23e or 28e-f ehow alson Examiner must be notilited at		57 Wade Lane	21901	United States
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	o- 14. Race - American Indian, Black, White, etc.
36	rs eft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:	1 ☐ Yes 2 📉 No Specify:	Specify: White
21215-0036	72 hours neturel', ilon Exp	ted	15. Decedent's Education 16a, D	ecedent's Usual Occupation	16b. Kind of Business/Industry
215	c	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of working ife. DO NOT use retired)	
2	D 50 5 50	Completed	12 4	Homemaker	Own Home
nd	9 7 >	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
ξ	d 2 should b th end Ment 7 ie marked treumatic e	2	David Cole Wikoff	Mary Irma Green	
Maryland	17.5			Mailing Address (Street and Number or Rural Route Numb	
	s 1 end 3 f Heeith Item 27 other tr		Andrew S. Wade/Son 266 20a. Method of Disposition 20b. Place of D	Dr. Miller Road, North Ea	20c. Location - City or Town, State
Baltimore,	4 0 = =		Table 2 Container 5 Englished Holl State	bandary 14,	
Ħ	permit. Pag Depertment Important: I eny Injury o		21. Signatur a Funeral Service Lightnes	nk Cemetery 2004 22. Name and Address of Facility Crouch Fi	Calvert, Maryland uneral Home
ñ	permit. Depertr Imports eny Inj		I When I would	127 South Main Street, Non	
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		
	Pnysician	() i	Immediate Cause (Final disease or condition	c=f2 ~-	Onset and Death
1	/Medical		resulting in death) a. Due to (or as a consequence of)		1.600
1	Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)	ed -	/ week
	ed set	line	if any, leading to immediate cause. Enter thirdenying Cause (Disease or injury	2	0038
	secul end ai-trer	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of)		many you
8760,	sete be executed physicien end the buriai-trensit		d		
89	deeth certificete be executed e ettending physicien end id for use as the burial-trensit	fedic	V		
Box	ettending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy	23d. Date of delivery
O. E		Physician/Medical	in the past 12 months? 1	5 Other (specify)	Month Day Year
P.O.	iaw requires thet the de as been signed by the e 2 should be deteched f	H.	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 23e. Did to	tobacco use contribute to the cause of death?
ds	w requires the	d b	Dm T. (Drubettes M	2.01(11 T)	Yes 2 No 3 Probably 4 @Unknown
8	w red	ete	Cin Atrolal Glandle	24a. Was	an 24b. Were autopsy findings available
8	The law ete has page 2 a	Completed	Color Actes of	auto	psy prior to completion of cause of death?
ţa	lan:	BeC	25. Was case referred to medica	1 ☐ Yes 26. Place of Death Check on	2 No 1 Yes 2 No
>	Physician: rthis certific rei director.	10	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Other: 4 Nur≸ing Home 5 Resi	
20	ng Pi		27. Manner of Death 1 ☑ Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)		how injury occurred
<u>s</u>	deeth.	cati	2 Accident investigation	M 1 Yes 2 No	
Division of Vitai Records,	Office Direct In by	Certification;	4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office 28f. Location (City or Tol	Street and Number or Rural Route Number, wn, State)
_	apita iours nerel filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place, and due to the	Caliso(s) and manner as stated
	To the Hospital or Attending Physician: The within 24 hours elic of desh. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner: On the basis of examination and/one)	r investigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
	With Comp	Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			(where one will	7722307	01/14/2004
_	5		30. Name and address of person who completed cause of deeth (Item, 23a) (Ty SHYBN TILBL KATEL)	pe, Print) MI) 123 Somperly Are 5	311ctan m)21921
	Sta Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,	
			Laborer		

Box 68760, P.0 Division of Vital Records, or Attending Physician:

certificate funeral director this After within 24 hours after death. To the Funeral Director: A the illed in by Hospital To the Func the e

Be Completed Certification: To

27. Manner of Death

Medical

1⊠ Yes 2 No

1 Natural

2 Accident

3 Suicide

29a. Certifie

4 Homicide

(Check only one)

State Registrar

25. Was case referred to medical 26. Place of Death (Check only one)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Found 28b. Time of investigation 6 X Could not be determined

28c. Injury at Work? Found at 5:40 a 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found in dwelling

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1322 Harwich Drive Waldorf, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 4 Nursing Home 5 Residence 6 St. ther (Specify) AT SCENE

28d. Describe how injury occurred

Unknown

29c. License number 29b. Signature and title of certifier hi. m.D

OCME

29d. Date signed (Month, Day, Year) JANUARY 15, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LI m.D LING

5 Pending

111 Penn Street, Baltimore, Maryland 21201

1 ☐ Yes 2 🔀 No

31. Date filed (Month, Day, Year) JAN 2 0 32. Registrar's Signature 2004

			1 - For State Registrar	State of Mary		artment of H			iene g. No. 20 (04 02748
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Deat Month		3. Time of Death
-3	/Media	cal	SHIRLEY	MOOD		41 01 T		Jan.		004 3:424W
	Examir	ner	4a. Facility Name (If not institution, give PRINCE GEOR		ITAI		Location of Death		4c. County of	E GEORGE
	Funeral		5. Social Security Number 6. S	ex . 7. Age (/r	yrs. last birthday) If Under 1 Year	If Under 24 Hrs.		. 9	. Birthplace (State or Foreign
	Director		218-38-8021	□M 2 XF 6	1 Yrs.	Months Days	Hours Min.	(Month, Day, 07 - 2	9-1942 V	Vashington DC
	pu s		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	Aaryla f sho	٥	Maryland Prince (•	ol Height:	5			1 ☐ Yes 2 🕍 No
	the the	Director	10e. Street and Number	eorge s	Сартс	10f. Zip Code	3	11	0g. Citizen of Wha	at Country?
	h with	al Di	5415 Brenner S	Street		20	743		U.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, it a Madical Examinar must be notified at once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates;	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
5	72 ho	eted	15. Decedent's E	ducation ade completed)	(Giv	edent's Usual Occupa s kind of work done of	luring most of work	tina	16b. Kind of Busin	ness/Industry
2	vithin ne. han	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,)		D.C. Duk	olia Caboola
75	filed v Hygie other t	CO	17. Father's Name (First, Middle, Last)	Secr	etary	18. Mother's Nam			olic Schools
Baltimore, Maryland 21215-0036	should be nd Mental I marked o	To Be	Lester Kid	lwell			Margare	et Jac	ekson	
, Mar	and 2 sh Balth and n 27 is n		19a. Informant's Name/Relationship (Russell L.	Wood (Husba	nd) 5415	ing Address (Street a Brenner S	Street Ca	apitol He	city or Town, Sta eights MI	ate, Zip Code) D 20743
ore	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Ob. Place of Disp cemetery, cre	osition (Name of imatory or other place	al	Date 20,	20c. Location - Cit	ty or Town, State
Ħ.	: Pag tment tant: jury		`4 □Donation 45 □ Other (Special	(y) -	Tee Crem		200		Clintor	, Maryland
Ba	permit. Departn Imports any inju		21. Sign were of Funeral Service Lice	1988		2. Name and Addres	1	ee_Funer		
			23a. Part 1. Enter the disease, or com	plications that caused the						Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final		0 == · 0 · /	F Mallin	OF			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. RESTIRI		FAILU	100			2 DAYS
100	Examiner		Sequentially list conditions.	b. ADULT	RESPIR	RATORY	DISTRE.	SS SYN	DROME	3 DAYS
- 45	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co						2
	xecut and	хап	that initiated events resulting in death) Last	c. SEPTIC Due to (or as a co	nsequence of):					2 WEERS
8760,	icate be executed physicien and s the burial-transit	al E	l	- CARCIN	IOMA	OF LU	NG			FMONTHS
9	uficate g phy as the	edic		u						
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	f delivery Day Year
	that in the plant is deta	y Ph	Part II. Other significant conditions	contributing to death but no	ot resulting in the i	inderlying cause give	n in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
rds	quires in sign	ed by	CEREBRO	VASQULA	R ACC	DENT		1 X Ye	s 2□No 3[Probably 4 Unknown
Division of Vital Records,	aw recs s bee	Completed	ELECTRO	LYTE IN	1BALA	NCE		24a. Was ar	24b. Wer	re autopsy findings available r to completion of cause of
Œ.	The I	E O						autopsy perform	1ed? d <u>ea</u> 1	r to completion of cause of th? Yes 2 □ No
/ita	clan: ertific ector,	Be	25. Was case referred to medical examiner?				26. Place of Deat			
5	shysi this c	ပ္	1 Yes 2 No	Hospital: 1 Nnpatient	2 ER/Outpatie		4 Li Nursing no	me 5 Reside		(Specify)
u	ding J	lou	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	Work	at ? ∕es 2 □ No	28d. Describe ho	w injury occurred	
isi	l or Attenoration after death Director:	ficat	2 Accident investigatio 3 Suicide 6 Could not b	e One Olege of leight	At home, farm, st			28f. Location /Str	eet and Number o	or Rural Route Number,
<u>></u>	al or A after I Direct d in by	Certification;	4 Homicide	building, etc. (S	pecify)	in a state of the		City or Town		, riorar riodio rioribor,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier 1 Certifying Pt (Check only one) 2 Madical Example	nysician: To the best of miner: On the basis of exa	y knowledge, dea mination and/or in	th occurred at the time	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)
	To the H within 24 To the F complete	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (A	Month, Day, Year)
•			I the take	of Taden	e	2006	-9519		1/15/2	2004
(1.6		30. Name and address of person who	·						
1	000		31 Date filed (Month Day Year)	32 Planistrar's			. SUITE 4	to7,51L	VER SPR	1NG, MD 20904
	Sta Registr		JAN 2 1	2004 32. Registrar's	Signaldy A	parker				

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Cora Weightman January 16, 2004 11:50AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Home Prince George's Clinton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M XEXT F 231 03 2311 89 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits * how r 28a-f show 1 ☐ Yes 2 ▼ Nyo Maryland Prince George's Clinton Direct 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ral', or Items 23a or Examiner must be 7520 Surratts Road 20735 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 VX If Yes, Give XX Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White d other than "natural", evant, It a Medical Ex Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank 12 Administrative Assistant 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) mit. Pages 1 and 2 should be fill bartment of Health and Mental Hyortant: If item 27 ie merkad oth njury or other traumetic even injury or other traumetic even Be Carl Albert Violet Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Weightman (husband) 6413 Morton Place, Temple Hills, Maryland 20748 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) ortant: Cedar Hill Cemetery Jan 19, 2004 Suitland, Maryland permit.
Departriments
Imports
any nit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d lattee M01/90 Alexandria Ferry Road, Clinton, Maryland 20735 el 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical CANDIO JASCULAN Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ as been si 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate ha 2 No 2 No 1 🗆 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes 2 No Certification: To 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No М investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DI8545 JANUARY 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 Old Line Centre Waldorf, maryland 20602 hilip Wisotsky MD 31. Date filed (Month, Day, Year) 32. A gistrar's Signature State JAN 2 1 2004 Registrar

	1 = For State Registrar	State of Maryland / Depa Ce	artment of Health and N rtificate of Death	fental Hygiene	2004 07/50
Physician /Medical	1. Decedent's Name (First, Middle, Last)	Rtis		2. Date of Death Month Day JANUARY	30, 2004 12:46 PM
Examiner Funeral Director	292-42-494 11 /	treet and number) HOOTE 7. Age (In yrs. last birthday) M 2 F 82 Yrs.	4b. City, Town, or Location of Death BOUTMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign
death with the Maryland rime 23e or 28e-f ehow rimest te notified at resist te notified at neval Director	Usuel Residence of Decedent 10a. State 10b. County 10e. Street and Number	10c. City, Town or Lo	ocation 1 MOYE, 10f. Zip Code	10g. Cit	10d. Inside City Limits 1 Yes 2 □ No izen of What Country?
5 2 M 5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tyes 2 XNo	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036 at 2 should be filed within 72 hours after lith and Mental Hygiene. 27 te merked other than 'natural', or ite retraumatic event, the Medical Examire To Be Completed by Fui	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) WORK WORKER 18. Mother's Name	ing 16b. K	ind of Business/Industry Pel Tind USTRY Sumame)
	OSCAR ARTIS 19a Informant's Name/Relationship (Tyr. SANDRA ARTIS	(baughter) 380	ng Address (Street and Number or Rui	Ave ba	HU, MD 21229
Baltimore, permit. Pages 1 at Department of Hea Important: If them any injury or othe	20a. Method of Disposition Burial 2 Cremation 3 Re Donation 5 Other (Specify) 21. Signature of Funeral Service License	ARBUTU	ssition (Name of matory or other place) S CMCHCKU (27) 2. Name and Address of Highlity (A)	20c. Lo 7-04 Ba Ughn C Gr	Himpre, MD eene Funeral Sru
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complic shock, or heaft falure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not en e cause on each line. Pirecursor Due to (or as a consequence of):		or respiratory arrest,	Approximate Interval Between Onset and Death A darys
NORMAN Box 68760, death certificate be executed e attending physician and nd for use as the burial-transit	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			pros
NO 6 Geath certific e attending F of for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions con-	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
Vital Record ution: The law requir certificate has been s rector, page 2 should	25. Was case referred to medical			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
on of sing Physical distribution: To	examiner? 1 Yes 2 No 27. Manner of Death 1 Valural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 ☐ Residence 28d. Describe how injur	
	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify) ician: To the best of my knowledge, deat		City or Town, State	
To the Hosp within 24 hour To the Funer completely fill	(Check only 2 Madicel Exemin one) 29b. Signature and title of certifier	er: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date and 29d. Dat	te signed (Month, Day, Year)
V	30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type,	P/7595	IAM	V30, 2004
State Registrar	31. Date filed (Month, Day, Year) FEB 0 3 2004	32. Registrar's Signature	de		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** $\underline{\varphi}$ 4:25 AM Grace Marie Ault 2004 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Martona 1501 0 LONICA If Under 1 Year if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2□ F Months Yrs. Director 214-36-7132 66 15, Mary1and Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f shor traumatic event, the Modical Examiner must be notified at No Yes 2 □ No Funeral Director Harford Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 627 Foxcroft Drive 21014 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐xNo 1 Yes 2 No Specify: white Specify: Completed by Year or Detes: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within nent of Heelth and Mentel Hygiene. int: if Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 years homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Shaffer John Bachtel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heelth a Important: if Item 27 Is any Injury or other tra Allen E. Ault/husband 627 Foxcroft Drive, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/31/04 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical METASTATIC BREAST CANCER Examiner Due to (or as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛱 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 20 No TU Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Other: 42 Nursing Home 5 Residence 6 Other (Specify) ၉ 3□ DOA 27 Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification:

nding physician end use es the bunel-trensit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this After this death. Director: A d in by the f

death with the Merylend

Baltimore, Maryland 21215-0020

1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

edicai

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of pertifier Willeysin 29c. License number 29d. Date signed (Month, Day, Yeer)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHANJANINO HAVRE DEGRACE, MD 21078 SURESH 6225.UNION AVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

FFR 0 3 2004

within 24 hours e To the Funeral C completely filled To the Hospital

			Please				elible Ink. En tment of Healti		-	-	
			For State Registrar	State of Ma			ificate of Dea			2004	02752
*	Physicia /Medic		1. Decedent's Name (First, Middle, Las Charles Norman		•				2. Date of Death January	29,2004° ar	3. Time of Death 12:25P M
	Examin		4a. Facility Name (If not institution, give 1705 South Road	street and number)			4b. City, Town, or Locati Baltimore			4c. County of Death	
	Funeral Director		5. Social Security Number 6. Se	7. Age	(In yrs. last birti		If Under 1 Year If Un Months Days Hou	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day, February	(ear) 9. Birth	place (State or Foreign intry) / l.and
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loca	ation				10d. Inside City Limits
	the Mar 28a-f sl	ector	Maryland N/A		Baltim	ore	10f. Zip Code		10	g. Citizen of What Cou	1√2Yes 2 No
	23a or	al Dir	1705 South Road				21209			USA	
036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Mexical Examine related by mullisst at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? XX Yes 2 N If Yes, Give Year or Dates:			as Decedent of Hispanic Yes, specify Cuban, Mex Yes 2 XXIO Spec		cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Whi	, etc.
Maryland 21215-0036	rithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5		life. DO	nt's Usual Occupation ind of work done during n O NOT use retired)	nost of workin	19	6b. Kind of Business/Ir	
2	e filed with Hygien other the	Be Co	17. Father's Name (First, Middle, Last)	4		Sal	18. M		(First, Middle, M	Pharmacel aiden Sumame)	JUICAI
rylar	should be filed vand Mental Hygie s marked other t umatic event, III	ToE	Charles Norman And		19h	Mailing	E] Address (Street and Nu		h Jones	City or Town State Zi	n Code)
	s 1 and 2 should of Health and Men item 27 is marke other traumatic		Virginia White And		Vife 17	05 5	South Road E	Baltimo	re, Mary		
altimore,	Pages 1: nent of He int: If iten iry or oth		20a. Method of Disposition 1 XX Jurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			y, crema	tion (Name of atory or other place) Ge Cemetery			oc. Location - City or T I Kesville,	
Baltin	permit. Pages Department of Important: If It sny injury or o		21. Signature of Funeral Service Licen		alo		Name and Address of Fa	acility Mitc	hell-Wiede		Home Inc.
* 3.	Physician		23a. Part1. Enter the disease, or companies, or companies, or companies, or companies, or companies, or companies, or companies, or condition	plications that caused one pause on each lin	10.	not enter	the mode of dying, such		respiratory arres	et,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence o	of):		.,,			
	be is	lner	Sequentially list conditions, if any, leading to immediate rause. First Incertying Cause (Disease or injury	b. Due to (or as a	a consequence o	of):					
,09/	e be executed sician and s burial-transit	cal Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence o	of):					
O. Box 68	at the death certificate I by the attending physi- tached for use as the b	Physiclan/Medlc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		ctopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
ds, P.	luires that t n signed by ild be detad	þ	Part II. Other significant conditions of		3			art I.		cco use contribute to t	the cause of death?
Division of Vital Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed	Ventricula	r Ta	chyca	ird	lia		24a. Was an autopsy performs	prior to co	opsy findings available ompletion of cause of
Vita	sician: Th certificate irector, pag	o Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	all EB/O		Othor		(Check only one		
n o	ng Phy dter this ineral d	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatie 28a. Date of Injur (Month, Day		Time of njury	28c. Injury at Work?	2	8d. Describe how	ce 6 Other (Special injury occurred	ny)
Divisio	To the Hospital or Attanding Physician: To the Funeral Director: After this cartifications with a funeral Director: After this cartification in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home, far c. <i>(Specify)</i>	rm, stree	M 1 Tyes 2		8f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
	ne Hospita n 24 hours ne Funeral	edical C			examination and		occurred at the time, date stigation, in my opinion,				
•	To the To the Comp	Me	29b. Signature and title of certifier	o-fing	CP ~		29c. License numb		290	d. Date signed (Month,	
	3		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, P			0 11		2004
	Sta	te	Robert T Cho 31. Date filed (Month, Day, Year)	243: 32/Registra	5 W ar's Signature	Be	Ivedere,	tre	Balt	imore M	D 21215
	Registr		FFR 0 3 20	04 Air	a still b	100					

			Please I	ype or Print					-		Jible.		
			For	State of Man					lental Hy	giene	nol.	0.2	752
			1 - State Registrar			Certifica	ate of	Death	1	Reg. No	004	UZ	100
	Physici	an	Decedent's Name (First, Middle, Last)	11					2. Date of Dea Month	Day	Year	3. Time o	/
	/Media		Regina	14 de	ms				01	30	2004	1800	4 M
	Examir	er	4a. Facility Name (If not institution, give			-		r Location of Death		-	nty of Deeth		
					ledical Ci		der 1 Year		Date of Birt	B		plece (State	or Foreign
М	Funeral		5. Social Security Number 6. Sex 1217-14-2695	7. Age (/	n yrs. last biri 81	Yrs. Month		Hours Min.	8. Date of Birt (Month, De) 11/26/1	Yeer)	Mary	ntry)	or roreign
	Director		Usuel Residence of Decedent						11/20/1	122	mary.	Tanu	
	yland		10a. State 10b. County		Oc. City, Town	n or Location						10d. Inside (
	Marian Marian	to	Maryland Anne Aru	nde1)dentor	ו						1 🗆 Yes	s 2 ∑ (No
	or 28	ire	10e. Street and Number				Zip Code			10g. Citizen d	of What Cou	ntry?	
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show the Modical Exeminer must be notified at	Funeral Director	2495 Amber Orchard	Ct. East A	Apt.# 2		113			USA			
	r dea	Inel	Tr. manar otata	 Was Decedent Eve Armed Forces? 1 ☐ Yes 2 2 No 	er in U.S.	13. Was De If Yes, s	cedent of H pecify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		lace - Ameri lack, White,		
36	or I	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		1 ☐ Yes	2 X No	Specify:		Spec	city: Whi	te	
21215-0036	hour	d be	15. Decedent's Edu		16a	Decedent's U	Isual Occur	nation		16b. Kind of	Rusiness/Ir	ndustry	
ις.	in 72 n" na	ojet	(Specify only highest grade	e completed)		(Give kind of life. DO NO	work done	during most of work	ing			,	
72	iene iene itte	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Вс	okkeep	er			Chesa	peake	Signs	Co.
ğ	illec I Hyg othe	Be Completed	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Sum	ame)		
<u>a</u>	Ald be Aenta rked tic ex	To B	Henry Schilling					Sophie Na	darzyns	ka			
Maryland	and heard heard heard		19a. Informant's Name/Relationship (Ty	pe, Print)	19b	. Mailing Addr	ess (Street	and Number or Rui	al Route Numbe	r. City or Tow	vn, State, Zij	p Code)	
Σ	and 2 palith n 27 i		Warren Adams	Husband				hard Ct.					2111
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23s or 28s-1 show any highry or other traumatic event, the Modical Examinet must be nutified at once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	lemoval from State	20b. Place of cemeter	Disposition (I ry, crematory o	Name of or other plac	Feb.	Date 1	20c. Locatio			
Ĕ	Pag ment ant: uny c		*4 □Donation 5 □Other (Specify)		Chesar			ion 2004		tevens	ATTTE	, FID	
Ball	Departition Depart		21. Signature of Juneral Service Licens	96	0			ss of Facility					
	00 = e 0		falled News	1101	342			ve. S.W.			D 2106		-10
- 6			23a. Fart1. Enter the diseese, or compleshock, or heart failure. List only or		e death. Doi	not enter the n	node <i>o</i> r dylr	ng, such as cardiac	or respiratory ar	rest,		Approxima Interval Be Onset and	etween
	Physician		Immediate Cause (Final disease or condition resulting in death)	(b)	ght	Cerel	se Von	~ Hem	or he	PP		246	oirs
	/Medical Examiner		Toolsting in doubly	Due to (or as a	onsequence	of):	,	-1					
100		<u>-</u>	Sequentially list conditions	Due to (or as a c	onsequence	of):							
	ted nsit	nin	Saquentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence	of):							
760,		a		d	,								
68	death certificate e attending phys id for use as the	ledi											
Box	h cer endin	Z/N	23b. was decedent pregnant	3c. If yes, outcome of 1□Live birth 2		3 □Ectopia	c oregnance	v			Date of deliv		Mana
	deal	sicia	in the past 12 months? 1 ☐ Yes 2 ☑No	4□Pregnant at tin		5 Other		<u> </u>		'	Month	Day	Year
P.0	at the	Physician/Medic	9 Unknown						an Dida		4-16		Cetterale
	requires that the de een signed by the a hould be detached t	b	Part II. Other significant conditions con	ntributing to death but	not resulting in	n the underlyin	ig cause giv	/en in Mart I.		obacco use co ⁄es 2 □ No		bably 4	
oro	neen s	Completed							0.00				-
ec	2 2	npie							24a. Was autop		b. Were auto prior to co death?	opsy findings ompletion of	cause of
E F	ate pag	S								2,8 No	1 🗆 Yes	2 ZNO	
Vital Records,		Be	25. Was case referred to medical examiner?	lospital:			DOA Ott	26. Place of Dea					
ō	Phys r this ral di	- To	1 Yes 2 PNo 27. Manner of Death	1 Danpatient 28a. Date of Injury		Itpatient 3	DUA	4 Nursing n	ome 5 Resid			<i>fy</i>)	
on	Attending Property of the funeral by the funeral	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	'ear) l	njury M	28c. Injui Woi	rk? Yes 2 □No					
Division	Attending in death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury		arm, street, fac	tory, office		28f. Location (S	Street and Nu	mber or Run	al Route Nui	mber,
Ö	afte s afte	Certification:	4 ☐ Homicide	building, etc.	Specity)				City or Tox	m, State)			
	To the Hospital or Attending Phyminin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral			sicien: To the best of									(a)
	hs H in 24 he Fi	edicai	(Check only 2 Medical Exami	ner: On the basis of ea and manner state		uvor investigat	uon, in my c	opinion, death occur	red at the time,	uate and plac	e, and due t	o the cause	(5)
	To t To t	Σ	29b. Signature and title of certifier				29c. Licens			29d. Date sig	ned (Month,	Day, Year)	
,	3		1//	many	0		Ro	95 000		1/20	104		
	. 2		30. Name and address of person who co			(Type, Print)	> //	95 000 more	d . A	0			
	T- 1-11		AD AN TRAN	32. R p trar	Krn	Ave	Balt	more	MA 2	1224			10-21
	St. Regist	ate	31. Date filed (Month, Day, Year)	32. Haptirar	s signature	Ave	. 20						
	100 00		4 20 - 4 -	- Company	The same of the	AVE 3.54	3						

			For	State of Marylar				and Men	tal Hygie	ene 2001	. 02751.
			State Registrar		Cei	tificate o	t Death	2.5	Reg	. No 00	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)						Jonth	Day Yeer	
	/Medic	al	4a. Fecility Name (If not institution, give	street and number)		4b. City. Town	n, or Location o	of Death	JAN.	31,2004 4c. County of Dea	4:10A ^m
	Examin	er	810 W. LEXINGTO				IMORE			N/A	
	Funeral		5. Social Security Number 6. Sec			If Under 1 Ye	ar If Under 2		Date of Birth Wonth, Day, Y	9. Bir	thplece (State or Foreign
Н	Director		238 56 9862 ¹⁰	M 2□F 64	Yrs.	Months Day	ys Hours	AL AL	JG. 14	,1939	NORTH
	pu ,	}	Usuel Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	cation					CAROLINA 10d. Inside City Limits
	sho	5	MD. N/A		BALTI						1√2 Yes 2 □ No
	1he h	Director	10e. Street and Number		DULLI	10f, Zip Cod	e		100	. Citizen of What C	ountry?
	3a or	0	810 W. LEXINGT	ON STREET			21201	l		U.S.A.	
	ours after death with the Maryland rel', or Hems 23a or 28a-f show Eversitier mout be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Orig	gin? (Specify	Yes or No-	14. Race - Am Black, Whi	
9	or Ite		1 Never Married Married	1 ☐ Yes 2 ☑ No		1 Tes Z		, , , , , , , , , , , , , , , , , , , ,	, 0.0.,		LACK
5-0036	be filed within 72 hours after ital Hygiene. Ind cher then "natural", or ite other then "natural", or ite event. It a Medical Examina	d by	3 Widowed 4 Divorced	Year or Dates:	,				4.0		
<u>.</u>	"nati	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Oc kind of work do DO NOT use ret	ne during most	t of working	10	b. Kind of Business	vindustry
12	withii iene. then	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	CHE	чτ			R	ESTAURA	אידי
0	filed Hygi other	Be C	17. Father's Name (First, Middle, Last)		CILL		18. Mothe	r's Name (Fir		iden Sumame)	
<u>a</u>	should be filed within of Mental Hygiene. marked other then imatic event, I'a M	To B	EDDIE EVANS				CF	AROLI	ME WIL	KES	
Maryland	2 4 4 5		19a. Informant's Name/Relationship (T) VALEISIA APSON		1	ng Address (Stre W. Lex				City or Town, State, O, MD. 2	
	of Health	1 3	20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date	20	c, Location - City or	Town, State
no	permit. Pages Department of I Important: if It any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Denation 5 ☐ Other (Specify)	temoval from State		natory`or other N FORE	^{piace)} FÉE ST VET	3 6 2 PÉRANS	2004 5 CEM	OWINGS	MILLS,MD.
altimore,	nit. Frankmer ortan injur		21 mature of Funeral Service Licens							AL HOME	112220 / 110
ä	permit. Departi Import. any inj		Dernadne,	1. Drug	1	412 E.	PREST	KUGGS FON_SI	FUNER BAL		21213
	33111		23a. Pert1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the dea							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	mo tasto	site	B-0	-sot	Ca	mce		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):						
125	Examine	_		b. Due to for as a consor	wearn of						
	bed isit	niner	cause. Enter Underlying Cause (Disease or injury	Des to (or as a consu	queries ory.						
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):						
760,	that the death certificate be ex ed by the attending physician detached for use as the buria	cal		d							
89	tificat g phy as th		_			173	2500			ACHIACA	
ŏ	th cer endin	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		∃Ectopic pregna	ancy			23d. Date of de Month	livery Day Year
P.O. Box	e dea he att	Physiclan/Med	in the past 12 months?	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)			WORTH	Day Tour
<u>Ч</u>	d by telach	Phy	9 Unknown Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause	given in Part I		23e. Did toba	cco use contribute t	o the cause of death?
ds,	w requires that been signed b should be deta	d by	Diabrite			, and any and a	3				robably 4 Unknown
Ö	v requ	ete							24a. Was an	24b Ware a	utopsy findings available
Re	4 2 2	Completed							autopsy performe	prior to death?	completion of cause of
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place	of Death (Ch		I □ Ye.	95.00
<u> </u>	Physician: r this certific ral director,	To B	examiner?	Hospital: 1 Inpatient 2]ER/Outpatie	nt 3 DOA				ce 6 □Other (Spe	ecify)
Division of Vital Records,	ing Phys After this uneral di		27. Manner of Ceath District 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. l	njury at Work?	28d.		injury occurred	
isio	Attending or death.	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm st		1 ☐ Yes 2 ☐ I		Location (Stre	et and Number or F	tural Route Number,
≥	al or A s after il Direct	Certification;	4 ☐ Homicide determined	building, etc. (Spec	ify)	ioot, ractory, on			City or Town,		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (sicien: To the best of my kn iner: On the basis of examin and manner stated.							
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Lic	ense number		290	I. Date signed (Mon	th, Day, Year)
			missel	sia mi	\circ	り	-27	921	1	12/01	+
	4		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type,					52	
	0			insten m	2	- 2	809	30	7040 ~	52	2124
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	December 1					2-12-4

ORIGINAL

			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of L	ealth and N Death		ne2004	02755		
	Physici /Medi		1. Decedent's Name (First, Middle, Las	RIGLIA				2. Date of Death Month JANUARY	Day 31 20	3. Time of Death		
	Examir		4a. Facility Name (If not institution, give NONTHWEST 1409	Street and number)	R	4b. City, Town, or RANDALL	Location of Death		4c. County of De BALTIN			
	Funeral Director		051-12-9634	7. Age (in yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo June 15, 1	9. Bi	rthplace (State or Foreign Country) aly		
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits		
	Mary B-f sh	tor	Maryland Baltim	ore	Catons	ville				1 ☐ Yes 21 No		
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	Country?		
	18 238	erai	4 L Baldwin Cour	t 12. Was Decedent Ever in U	6 121	21228		anife Van au Na	U.S.A.	orione ledice		
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or terms 23e or 28e-f show event, the Medical Examination in the Medical Examination.	by Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	1	Vas Decedent of Hi f Yes, specify Cubar I □ Yes 2ᡌ No	Specify:	Rican, etc.)	Black, Wh			
2-0	72 hor	eted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	lent's Usual Occupa kind of work done d	urina mast at work	ing 16I	b. Kind of Busines:	s/Industry		
21215-0036	within ene. then "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use retired, as Clerk)		U.S. Gov	. 		
d 2	filed withi Hygiene. other then ent, ILE M	a l	17. Father's Name (First, Middle, Last)		Oldin	is ofer	18. Mother's Nam	e (First, Middle, Mai		ermient		
/lan		To B	Anthony Briglia				Gilda Co	rbellini				
Maryland	C1 G = 20		19a. Informant's Name/Relationship (7	· · · · · .				al Route Number, C	-			
	is 1 and 2 of Health item 27 other tra		Lydia Bennett (Co	ousin)	Place of Dispo	sition (Name of		nsville,	Maryland Location - City o			
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		natory or other place n Cemetei	· 1			rg,Maryland		
Balt	permit. Page Department of Important: If any injury or once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsvill 1630 Edmondson Ave Catonsville, M										
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deat						Approximate Interval Between		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		HINOR	•				Onset and Death		
	Examiner		ſ	Due to (or as a conseq	uence of):							
	ש בּ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):							
	and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	neuce ot).							
68760,	icate be executed physician and s the burial-transit	edicai E		d								
		Medi	IF FEMALE:									
P.O. Box	The law requires that the death certific ate has been signed by the attending ploage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year		
	ires that signed b d be deta	ρ	Part II. Other significant conditions co CHRONIC LYMP	ntributing to death but not res	ulting in the ur いんとの	derlying cause give	n in Part I.	23e. Did tobac		o the cause of death?		
cor	aw requir is been si 2 should I	Completed	PROSTATE C	ANCER .				24a. Was an	24b. Were a	utopsy findings available		
I Re		Som				7		autopsy performed 1 Yes 2,2	prior to death? No 1 \(\sum Yes	completion of cause of		
Vita	Physicien: this certifical	Be	25. Was case referred to medical examiner?	Hospital: X		Oth		h (Check only one)				
of	Phys r this ral dir	٠ <u>.</u>	1 ☐ Yes 2 No 27. Manner of Death	1 ∠ ngpatient 2 ⊔	ER/Outpatient 28b. Time of		4 Li Nuising no	me 5 Residence 28d. Describe how i		ecify)		
<u>io</u>	nding F ath. r: After e funer	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work' M 1 □ Y	? es 2 □ No		injury occurred			
Division of Vital Records,	I or Attending after death. Director: After I in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S		ural Route Number,		
X	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy one) 2 Medicel Exem	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occurr	and due to the cause red at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)		
	1-	Σ	29b. Signature and Many certifier	PHYSICIA1		29c. License	2723	, ger	_	31 20041		
	9		30. Name and address of person who c			Print) NORT 5401	OLD CO	1905013 1905013	CAC (M) 21133		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 3 200	32 Registrar's Signa	ture	ule						

			1 - For State Registrar	State	e of Ma	aryland		artmen				lental Hy	giene	-201) <u>L</u>	02756
			Decedent's Name (First, Middle	, Last)								2. Date of Dea	ath			3. Time of Death
h	Physici /Medic		MILDRED E	STELLE	Τ.	ARMOR	E	BYE	ERS			Month Janua	ry :		_{ear} 004	8:30 A M
	Examir		4e. Fecility Name (If not institution	, give street and				4b. City,	Town, or	Location	of Death			. County of		
			13204 Falls F					+		vill						County
	Funeral		5. Social Security Number 217-05-9647	6. Sex 1 ☐ M 2 [X]		e (<i>In yr</i> s. Ia 85	st birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da	h y, Year)			ace (State or Foreign
12	Director		Usuel Residence of Decedent			0,7						Sept 4	, 19	18	Mar	yland
	ylanc		10a. State 10b. County	_		1	Town or Lo		_						10	Od. Inside City Limits
	e Ma	ctor	Maryland Baltim	ore Cou	nty		Cocke	ysvil	le							1 ☐ Yes 2 No
	or 24	Director	10e. Street and Number					10f. Zip		000			10g. Cit	izen of Wha		try?
	s 23s		13204 Falls R		Donadast I	Ever in U.S	12)4/ D		.030	-:-0 /0	N-		USA		an fastion
	tter de	Funeral	11. Marital Status 1 □ Never Married 2 □ Marr	Arme	d Forces?					n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		Black, 1		
036	al', or	þ	3 ₩ Widowed 4 Divorced	If Yes	, Give or Dates:			1 ☐ Yes 2	X No	Specify:				Specify:	Wh	ite
2-0	within 72 hours after death with the Maryland ene. than "naturs!", or Items 23a or 28a-f show the Medical Exercitar must be toolified at	Completed	15. Deceden (Specify only highes	's Education	ted)		16a. Dece	dent's Usua kind of wor	il Occupa	ation Turing mos	t of worki	na	16b. K	ind of Busin	ess/Ind	ustry
121	within ne.	mpl	Elementary/Secondary (0-12)	1	ge (1-4or 5	i+)	life.	DO NOT us	e retired,)			Dwi	wata.	C_1	Laga
N 0	filed v Hygie other t		12 yrs 17. Father's Name (First, Middle,	Last)			Seci	etary		18. Mothe	r's Name	(First, Middle,		vate	COT.	rege
Maryland 21215-0036	Mental Mental arked o	To Be	Richard Elme		ore							et Estel		Hoff	man	
ary	shound M mar		19a. Informant's Name/Relations				19b. Maili	ng Address	(Street a			I Route Numbe				Code)
	and 2 alth a 127 ls		Bruce L. Byers		(Son)		13204	Fall	s Ro	ad, (Cocke	eysville	e, M	lary1a	nd 2	21230
ore	of He		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal tr	rom State	20b. Pla	nce of Dispo	sition (Nam	ne of			ate		ocation - Cit		
Ē	Pages Iment of tant: If it jury or o		* 4 ☐ Donation 5 ☐ Other (S	pecify)		Gra	ce-Fa	lls Ro	lUl	M Cem	2/4	/2004	Cocl	keysvi	11e	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturst", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examiner must be rediffed at QRG.		21. Signatura of Fune al Service	Lau	mon	_	22	2. Name and Mitche	d Addres	s of Facilit Winede	feld	Funera	1 H	oraca T	ne	
			Martin D.]	Lawson	nat caused	the death	Do not ent	6500 N	York	Road	, Ba	ltimore	. Me	arylar	$\frac{1}{2}$	1212
			shock, or heart failure. List Immediate Cause (Final	only one cause	on each lin	10.	1/0		o or aymig	g, 30011 a3	oaroiac o	i respiratory at	1631,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due	17	a conseque	V U								_ :	± 2465.
n	Examiner		25-5		(0. 40	a 001100qu	31100 017.									
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Under in	D. Due	to (or as	a conseque	ence of):									
	ecuted and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c												
760,	ite be executed iysician and ne burial-transit	cal E	rooding in oddiny 2200	Due	to (or as	a conseque	ence or):									
687	3 3 9			d												
Box	death certifica e attending ph id for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant			of pregnan		-						23d. Date of	f deliver	Y
	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 X No	4□P	regnant at	2 Fetal of time of dea		Ectopic pre Other (spe						Month	(Day Year
о. О	at the de by the a	hys	9 Unknown		nknown								1			
	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant condition	ons contributing	to death bu	ut not result	ting in the u	nderlying ca	tuse give	n in Part I.						a cause of death?
ord	w require been si should l	ted										1 O Y	es 2	№ 0 3[_ Proba	bly 4 □Unknown
Vital Records,	has b	Completed										24a. Was a autop perfor	SV	prior	to com	sy findings available pletion of cause of
a												1 Yes	2 X No	deat	Yes 2	2□ No
Ĭ	ysician: is certific director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	☐ Inpatie	- 2 D C	R/Outpatier	nt 3 DQ	_ Othe			(Check only or ne 5 Resid		. 50:		
0	g Phys er this eral di		27. Manner of Death	28a. D	ate of Injur	y 2	8b. Time of		Bc. Injury	at	-	28d. Describe h			Specity)	
0	Attending F death. ctor: After y the funer	atlo	1 Natural 5 Pendin 2 Accident investig	pation	Month, Day	(1641)	Injury	М	Work 1 □ Y	es 2 🗆	No					
Division	il or Attend after death Director: / d in by the f	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. P	lace of Inju	ury - At hom c. (Specify)	ne, farm, str	eet, factory,	office		2	28f. Location (S City or Tow			r Rural	Route Number,
	urs af										1					
>	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only 2 Medical one)	g Physician: To Examiner: On the	the best on the basis of manner sta	examination	ledge, death on and/or in	h occurred a vestigation,	at the tim in my op	e, date an inion, deal	d place, a th occurre	and due to the o ad at the time, o	ause(s) date and	and manne place, and	r as sta due to	ted. the cause(s)
	o the	Me	29b. Signature and kitle of certifier		/			29c.	License	number		2	29d. Dat	te signed (M	fonth, D	ay, Year)
	- > - 0		DE COME	AF	U	mi.	ow		DI	1951	53		1-	-30	- (4
	4		30. Name and address of person		cause of de	eath (Item 2	23a) (Type,	Print)					1		-	1
	U	Ш	Edward P. Cost	low, M.	D., 1	0 Ger	ard A	venue	, Ti	moniu	m. N	aryland	21	093		
	Sta		31. Date filed (Month, Day, Year)	8/ 3	2. Registra	ar's Signatu	Saace.	1			n 700 5 (1550)		া এবাসী	notice.		
100	Registr	ar	FEB 0 3 200	To alexander		- 1										

			For State Registrar	State of Maryland /	Depa Cer	artment of I tificate of	lealth an <i>Death</i>		giene2 () (14 02757
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day, Y	3. Time of Death
	/Media	al	Maria Braun 4a. Facility Name (If not institution, give s	etroet and number)	-	4b. City, Town, o	or Location of D	Jan.	26 20 4c. Obunty of	Death
	Examin	er	St. Elizabeth Nur			Balti		,outil	To: County of	50411
Ī	Funeral Director	1	5. Social Security Number 6. Sex		birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth	'9 ^Y fa')). Birthplace (State or Foreign Country) MD
T	pun		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
	Aanyle I sho	ō	MD		ltimo					1 Yes 2 □ No
	286-	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	3a ou	Funerai Director	220 Stonecroft Rd.			21:	229		U.S.A	•
	deati	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of I	Hispanic Origin'	? (Specify Yes or No- uerto Rican, etc.)	14. Race -	American Indian, White, etc.
36	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		I□Yes 2 Z No			Specify:	White
Ö	tural.	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu		Sa Deced	lent's Usual Occu	pation		16b. Kind of Busi	
21215-0036	in 72 n *ne n *edic	Completed	(Specify only highest grade	completed)	(Give	kind of work done OO NOT use retire	during most of ed)	working	TOO. THING OF BUSI	nosamodany
212	d with piene.	Шo	Elementary/Secondary (0-12)	College (1-4or 5+)	Insp	pector			Electri	cal
힏	e filec al Hyç I othe vent,	Be C	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Sumame)	
yla	Ment Ment arkac	10	Frederick Sieber					a Owens		
Maryland	nd 2 sho alth and 27 Is m		19a. Informant's Name/Relationship (Ty) Louis Russo - Fri		9b. Mailin 08 Lo	g Address <i>(Str</i> eet ong Islan	nd Ave.	Apt. E Ba	r, City or Town, St lltimore,	ate, Zip Code) MD 21229
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Evertil at final by netiting at ance.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other pla /Washing		Date 29/2004 I	20c. Location - Ci	
	nit. P artme orten injur.		21. Signature of Funeral Service License		22	. Name and Addre	ess of FacilityW	itzke Fune		of Catons-
ä	Per Per Per Per Per Per Per Per Per Per		Demanh	Talouske	フvi	lle 1630	Edmond	son Ave. C	Catonsvil	le, MD 21228
	/Medical Examiner	iner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e cause on each line. De M & Due to (or as a consequence)	Ce of):	h'a	ng, such as car	ulac or Tespiratory an	0 51,	Approximate Interval Between Onset and Death JULA
8760,	icate be executed physician and s the burial-transit	icai Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):					
.O. Box 6	death certif e attending ed for use a	Physician/Medical	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnanc Other (specify)	у		23d. Date of Month	
٥.	juires that n signed b ild be deta	by	Part II. Other significant conditions con	tributing to death but not resulting	g in the ur	nderlying cause gr	ven in Part I.	23e. Did to	Δ.	ute to the cause of death?
of Vital Records,	The law requires that the ate has been signed by th bage 2 should be detache	Completed						24a. Was a autopo perfor	med? dea	re autopsy findings available or to completion of cause of th?
ita		Be C	25. Was case referred to medical				26. Place of	Death (Check only or		
on of V	Phys this al di	은	27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 ER/ 28a. Date of Injury (Month, Day Year) 28b	Outpatien Time of Injury	28c. Inju	ry at	ng Home 5 Residence 28d. Describe he	ence 6 Other	
Division	in Eight	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tniury - At home, building, etc. (Specify)	farm, stre			28f. Location (S City or Town	treet and Number n, State)	or Rural Route Number,
X	To the Hospitel within 24 hours and the Funerel completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my knowled her: On the basis of examination and manner stated.	lge, death and/or inv	occurred at the ti restigation, in my	me, date and popinion, death o	lace, and due to the coccurred at the time, d	ause(s) and mann late and place, and	er as stated. I due to the cause(s)
	To the I within 2 To the complet	Me	29b. Signature and time of certifier	(m	2	29c Licen:	2 746	6	29d. Date signed (i	Month, Day, Year) 28, 2007
	6		30. Name and address of person who co	mpleted cause of death (Item 23a	a) (Type, Wa	Print) dea	de	rice las	al Do	28,2007 CLUD 21228
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 3 20	32. Registrar's Signature	100	ede .				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\frac{M^{\text{onth}}}{1/28/04}$ **Physician** CHARLOTTE **BROTHERS** 1:55 AM /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MAINER HEALTH CATONSVILLE CATONSVILLE BALTO. | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 11/28/30 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 154 22 0719 73 Yre MD. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-fahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No BALTO. CATONSVILLE Directo 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code or Items 23a or 114 WESLEY AVE. 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 ₩Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) LAW FIRM CLERK 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked othe any injury or other traumatic event, sone. 17. Father's Name (First, Middle, Last) Be SENORA GEORGE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 3021 PULASKI HYWY. BALTO. MD. LATONYA JOHNSON G/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State PIKESVILLE, MD * 4x Donation 5 ☐ Other (Specify) DRUIDRIDGE 2/3/04 21. Signature of Fune al Service Licens 22. Name and Address of Facility ESTEP BROS. FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217 seul a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA 2YAG GWT /Medical Due to (or as a consequence of): **Examiner** DEMENITIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à, - CHRONIC RENAL FAILURE 1 - Yes 2 - No 3 Probably 4 Unknown MULTIPLE ns certificate has been si director, page 2 should l Completed ENTIAL HYPERTENSION NSIVE CARDIOVASCULAR GE SACRAL DECUBITUS ESSENTIAL WITH HYPERTE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has autopsy performed? DISEASE autopsy performed?

Yes 250No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 25 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Medical Certification: 1 Natural 5 Pending s after do. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number D18362 2-2-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455, Wilkens Ave. Suite 308. Balto. Md 21229 K. DANG M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 3 2004 Registrar

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of He			giene Reg. No. 20	02760
	Dhusis		Decedent's Name (First, Middle, L.	ast)				2. Date of Dea Month	ath Day Ye	3. Time of Death
g	Physic /Medi		BERTHA BI	215005				JAN	31 20	
1	Exami		4a. Fecility Name (If not institution, g.			4b. City, Town, or Lo	ocation of Death		4c. County of D	Peath
			Howard Co. Ge	1.		Columbi	a		Howa	rd
	Funeral			Sex 7. Ag 1 ☐ M 2 💢 F	ge (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De)	h v. Yeer) 9.	Birthplace (State or Foreign Country)
15.1	Director		219-10-9079	1 M 2 M F	81 Yrs.	, ,		9-7-2	B.	ld.
- Inter-	pur		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	neation				10d, Inside City Limits
	anyla	2	Tob. County		Too. Gity, Town of Ed	Cation				1 ₩ Yes 2 No
	Ba-f	ecto	Md, NA		Baltim					21
	vith ti	Director	10e. Street and Number		77.6	10f. Zip Code	,		10g. Citizen of What	Country?
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Exaculate must be rediffed at	Funeral	1701 Eutaw Plac	-		21217			USA	
	er de Rem	une	11. Maritat Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto I	city Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc.
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ② Divorced	1 ☐ Yes 211 If Yes, Give Year or Dates:	No	1 ☐ Yes 🏖 No	Specify:		Specify:	Black
5-0036	tural	Pa Pa	15. Decedent's		163 Dage	dent's Usual Occupation	20		16b. Kind of Busine	and advates
5	n 72	Completed	(Specify only highest g	rade completed)	(Give	kind of work done dur DO NOT use retired)		ng	166. Kind of Busine	ess/industry
2121	iene.	Ę	Elementary/Secondary (0-12)	Cotlege (1-4or	5+)	lerk			Social So	curity Admin.
	Hygin Hygin ther		12th grade 17. Father's Name (First, Middle, Las	t)			8. Mother's Name		Maiden Sumame)	CULILY Admin.
an	Mental Mental arked o	Be C	James	Bris				(, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,	,	
$\overline{\Delta}$	should nd Men merke umatic	2	19a. Informant's Name/Relationship			ng Address (Street and	Bessie	l Route Mumbo	r City or Tour Stat	Keene
Maryland	0 00 00									
_	s 1 and of Health item 27 other tr		20a. Method of Disposition	aughter	20b. Place of Dispo	Country Min		Baltimo ate	20c. Location - City	21223
Baltimore ,	0 0		1 Burial 2 □ Cremation 3		cemetery, crei	matory or other place)	1		200. Eddalloll Oily	or rown, stote
tim	permit. Pag Department important: I eny injury o		9 □ Bonation 5 □ Other (Spec		King Me		2-5-0		Randalls	
Bal	Departimbo		2) Signature of Funeral Service Lice). I A	11 /	2. Name and Address			ltimore,	
	40.2 4 0		23a Pani. Enter the disease, or co	walling	-//	March F.H.		1101	E. North	Ave.
The second	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Under hin Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or es	a consequence of):	, ROFAR	chok			Onset and Death
P.O. Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ ₩0 9 □ Unknown	d23c. If yes, outcome	2 Fetel death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Records, P.	signed b	by	Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause given i	in Part I.			e to the cause of death? Probably 4 🖂 🖽 Known
Ö	w requir been si should I	Completed	1000 5-00	c 00:	0 - 2	20100				
360	sicien: The law certificate has t irector, page 2 s	mp			AZ DI	36 KC		24a. Was a autops perform	sy prior	autopsy findings available to completion of cause of
E	cate		HYPERTS	このつりり				1 Yes		es 2□ No
Vital	ician Sertif ector	Be	25. Was case referred to medical examiner?	Hospital:			6. Place of Death			
of	this a	မ	1 Yes 2 No	1 La Inpatie	ent 2 ER/Outpatien	t 3 DOA Other;	4 Nursing Hom	ne 5 Reside	ence 6 Other (S	pecify)
Division	tending Physician: The la leath. tor: Alter this certificate has the funeral director, page 2	Cert fication:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	ne -		Work? M 1 ☐ Yes	s 2□No		ow injury occurred	
Divi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined	building, et	9-9-		e se seguide	City or Town	n, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best miner: On the basis o and manner st	of my knowledge, death f examination and/or in- ated.	vestigation, in my opini	on, death occurre	nd due to the c d at the time, d	ause(s) and manner ate and place, and d	as stated. lue to the cause(s)
	To To CONT	2	29b. Signature and title of certifier	Llue l	arozMD	29c. License ni			9d. Date signed (Mc	2004
	10		30. Name and address of person who		eath (Item 23a) (Type,	Print) 11055	S LIT	TLS	PATUXS	ar PKan
	1			SCIDACY	51	COL	untsiv	7/m	1)	
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	a. 1.1		,		

			Sor State RagistrAMEND ITEM #5 PER	tate of Maryland	I / Depa	artment of H	ealth and N Death		ene 20 (04 02761
	Physici		1. Decedent's Name (First, Middle, Last) BETTY		OWSK1			2. Date of Death		3. Time of Death 18:30 pm
	/Medic Examin		4a. Facility Name (If not institution, give stre Univ. of Maryland		yst	4b. City, Town, or Baltin			4c. County of D	
	Funeral Director		5. Social Security Number 218-18-8194 218-28-8194 Usual Residence of Decedent	7. Age (In yrs. late 70	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Sept. 27	9. 1933 M	Birthplace (State or Foreign Country) Iaryland
	Maryland f show	or	Usual Residence of Decedent 10a. State Md. Anne Arund		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the Page or 28e-	I Director	10e. Street and Number 268 10th Street		- 4544	10f. Zip Code	21122	10g	g. Citizen of Wha	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumetic event, the Medical Examinar must be notified at once.	by Funeral		Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	1	Vas Decedent of Hi f Yes, specify Cubar □ Yes 2 🕅 No		pecify Yes or No- p Rican, etc.)		American Indian, Vhite, etc. White
Baltimore, Maryland 21215-0036	d within 72 ho jiene. r than "naturi ihe Medical I	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)		(Give	lent's Usual Occupa kind of work done d DO NOT use retired, 1aker	uring most of world	king 16	Own Hon	•
/land	uld be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last) Allen W	ebster			18. Mother's Nam Doroth	ne (First, Middle, Ma Y	iden Sumame) Luc	as
, Mary	and 2 sho saith and ! n 27 is ma	ij	19a. Informant's Name/Relationship (Type, Thomas R. Borowski	Sr.(Husband)	268	10th Str	eet, Pasa	ral Route Number, C adena, Md		te, Zip Code)
imore	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	cen	netery, cren	sition <i>(Name of</i> natory or other place Islaus Cei)	Date 20 2/02/04	oc. Location - City Baltimor	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensed	my ton &			y-Polynia ountain l	ak Funera Road, Pas		A. Id. 21122
j	Physician		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of immediate Cause (Final disease or condition	ions that caused the death, ause on each line. Metastatic					t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions, b.	Due to (or as a conseque						
8760,	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						
.O. Box 68	The law requires that the death certificat to has been signed by the attending phy age 2 should be detached for use as the	Completed by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 ☑ No 9 □ Unknown	If yes, outcome of pregnand 1 □Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3 🗌	Ectopic pregnancy Other (specify)		Tik	23d. Date of Month	delivery Day Year
Δ.	quires that n signed b uld be deta	d by Pr	Part II. Other significant conditions contrib	uting to death but not result	ing in the un	nderlying cause give	n in Part I.		_	e to the cause of death? Probably 4 □Unknown
Division of Vital Records,	: The taw require cate has been si, page 2 should t	Complete						24a. Was an autopsy performe 1 XYes 2	d? deat	autopsy findings available to completion of cause of h?
	Physician: r this certifica ral director, I	To Be	25. Was case referred to medical examiner? 1 Yes X No	oital: X□ Inpatient 2□ El	R/Outpatient	t 3□ DOA Othe		th <i>(Check only one)</i> ome 5 🗆 Resident	ce 6 □Other (5	Specify)
ion o	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Diractor: After this certificate ha completely filled in by the funeral director, page	atlon; 1	Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 2 (Month, Day Year) 2	8b. Time of Injury	28c. Injury Work	at ? ′es 2 ∐ No	28d. Describe how		. "
<u>Divi</u>	Hospitel or Atta 24 hours after de Funerel Diracta etely filled in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S		r Rural Route Number,
k	To the Hosp within 24 hou To the Funel completely fil	Medical	29a. Certifier 1 Cartifying Physici (Check only one) 2 Madical Examiner	an: To the best of my knowl On the basis of examinatio and manner stated.	ledge, death on and/or inv	estigation, in my op	inion, death occur	red at the time, date	and place, and	due to the cause(s)
	To the within 2 To the complex	2	29b. Signature and title of certifier	RESIDEA		29c. License P 1 6 5 9		Fek	Date signed (M D 2 , 2	onth, Day, Year) 004
_	10		30. Name and address of person who comp Gopal Gupta, MD 2	leted cause of death (Item 2 2 South Gre	a) (Type, Feene	St. Bal	timore,	Marylar	nd 2120	1
	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 3 2004	32 Registrar's Signatu		all)				

		•	for State				d / Depa		t of H	ealth a		lental Hyg		-	02	762
			Registrar 1. Decedent's Name (First, Middle	. Last)								2. Date of Deat	1		3. Time of	Death
	Physicia	an		ord		Berg						Month January	Day 25	Yeer 2004	6:40	a ^M
	/Medic		4e. Fecility Name (If not institution		nd number			4b. City.	Town, or	Location o	of Death			unty of Deetl		a
	Examin	er	1212 Quantril		710 110111001	,				ore C				/A		
-	- Farmer		5. Social Security Number	6. Sex	7. A	ge (In yrs. I	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth			nplace (State o	or Foreign
	Funeral Director		223-34-7415	1 🖾 M 2[80	Yrs.	Months	Days	Hours	Min.	July 12,	1921	3 Id	aho	
			Usual Residence of Decedent							1						
	yland		10a. State 10b. County			10c. City	y, Town or L	ocation							10d. Inside C	
	a-1-e	to	Maryland N/A			Balt	imore	City								2 No
	th the	Directo	10e. Street and Number					10f. Zip	Code			11	g. Citizen	of What Co	untry?	
	th wi		5129 Wright Av	7e.					1205				USA			
	ems ems	Funeral	11. Marital Status	12. Wa Am	s Deceden	t Ever in U.	S. 13.	Was Deced	dent of Hi	ispanic Ori in, Mexicar	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, White		
õ	or it	y Fu	1 Never Married 2 Marr	l If Y	Yes 2 ☐ es, Give			1 🗆 Yes		Specify:			Spi	ecify: W	hite	
0500-6171	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow the Madical Examiner must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced		ar or Dates	:WW II	1						101 101-1	4 D	and unter	
D	nat	Completed	15. Deceden (Specify only highes	s Education t grade comp	leted)		(Give	dent's Usua kind of wo DO NOT us	rk done d	during mos	t of work	ing	16b. King (of Business/	ridusiry	
	Mithir Then I hen	E D	Elementary/Secondary (0-12)	Col	lege (1-4or	5+)		Cutte		,			4.8.P	Marke	te	
N	Hod Hyginal		17. Father's Name (First, Middle,	Last)			IICat	Ou C C		18. Mothe	er's Nam	e (First, Middle, M			<u> </u>	
maryland	intal ed o	Be c	Unknown	,						Unk	nown					
Ξ	ages 1 and 2 should be f nt of Health and Mental h t: If Item 27 is marked of y or other treumatic eve	2	19a, Informant's Name/Relations	hip (Type, Pri	nt)		19b. Maili	ing Address	(Street a	and Numbe	er or Rui	al Route Number,	City or To	wn, State, Z	ip Code)	
200	d2s th an th an treu					. ~h + ~ ~	1.22	/ D4=	ower and	1 I am	. v	ork DA	17403	,		
er er	1 and Health tem 27		Elizabeth A. Wi	TITIAMIS	(Dat	20b. P	lace of Disp	osition (Nat	me of			Date	20c. Locati	ion - City or	Town, State	
ᅙ	Pages nent of int: If it iry or o		ty⊡ Burial 2 ☐ Cremation • 4 ☐ Donation 5 ☐ Other (S		from Stat		emetery, cre idon Pa				1/29	/04 E	altin	nore.	Maryla	nd
saltimore,	artme porten injur		21. Signature of Funeral Service									don Park				
n n	permit. Page Department of Importent: If eny injury or once.		1									Baltimor				
Н	100		23a. Part1. Enter the disease, or	complications	that cause	ed the deat	h. Do not en	ter the mod	de of dyin	g, such as	cardiac	or respiratory arre	est,		Approximat	le e
	Physician		shock of heart failure. List Immediate Cause (Final				_								Onset and	Death
	/Medical		disease or condition resulting in death)			OVASC	ular (Colla	pse							
	Examiner				,											
	十二卷	Je.	Sequentially list conditions,	B	ue to (or a	s a conseq	uence of):									
	e be executed /sicien and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c												
Ď	en ar rial-t		resulting in death) Last	τ	Due to (or a	is a conseq	uence of):									
200	cate be physici the bu	Ical		d												
Q Q	The law requires that the death certificate the has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medi	IF FEMALE:													
ROX	eath certific attending p	an/	23b. Was decedent pregnant			e of pregna 2 Feta		□Ectopic p	regnancy	,			23d	Date of deli Month		Year
	o dea	Sici	in the past 12 months?		Pregnant Unknown	at time of d	leath 51	Other (sp	oecify)					William	5-1,	
J.	at the de	Phy	9 Unknown			-				la Dani		22a Did to	2222 1122	agatributo ta	the cause of	doath?
ທົ	res that igned be be det		Part II. Other significant condition Cardiomyopathy		ng to death	but not res	uiting in the i	underlying (ause giv	en in Parti			s 2 \square N		obably 4	
פ	w requir been si should	ted		<u> </u>												
Vital Hecords,	law las bu	Completed by	COPD									24a. Was a autops	v	prior to d	topsy findings completion of o	available ause of
_		00										perform	2 X No		2□ No	
ıta	Physicien: Th this certificate al director, pag	Be	25. Was case referred to medica examiner?						O.1			th (Chack only on			ughter.	
	hysia this c	ို	1 ☐ Yes 2 ☑ No	Hospita	1 🔲 Inpa		ER/Outpatie			4 LINI	ursing He	ome 5 Reside			Resi	dence
_	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir		. Date of Ir (Month, L	olay Year)	28b. Time of Injury		28c. Injun Wor			28d. Describe ho	w injury o	ccurred		
S S	tend death tor: /	cat	2 Accident investi	not be			,	М		Yes 2□	NO	206 Leasting (Co		umbarar O.	ant Dougla Mus	- hor
Division of	or At fler d Direct in by	Certification:	4 Homicide determ		building,	etc. (Specif	ome, farm, s fy)	treet, factor	у, опісе			28f. Location (St City or Town		amber or Ac	IIAI MOULE IVUII	1001,
	pitel ours a erel E		20. Continu	Dhusisian	To the her	nt of mu kas	uniodas dos	th converse	l at the tre	no doto o	nd place	and due to the or		d mannar ar	ctated	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director.	Medical		Exeminer: O		of examina						and due to the ca red at the time, d				s)
	o the ithin in the imple	Mec	29b. Signature and title of certifie	h .	- Indiana			29	c. Licens	e number		2	9d. Date s	igned (Monti	n. Day, Year)	
)	F ₹ F 8		165	11	1		No	'	*	51883	3		FER	3RD.	2004	
	X		30 Name and address of person	o complete	ad cause o	f death (Item	n 23a) (Typo	Print)								
	t,		DIAAY MIKHI	gir. M.	A . //	65 A	1 Poss	r Bu	VO .	1118	BA	LTIMOTE;	Mb 2	1224		
	and the St	ate	31. Date filed (Month, Day, Year,	7 17	32 Regis	strar's Signa	ature	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	/	7 007	-					
	Regist		31. Date filed (Month, Day, Year,	2004	1	108mm ph	the A	BASE	•							
	1141435		E Brow Tool		A. Harrison	-	300					277	- 11			

			ricasci	State of Maryla					•	niene	2001	00760
		-	For State Registrar	Otate of Maryla		rtificate				Reg. No.	2004	02763
jo.			Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Death
	Physici		Bohumi	l F. Ber	an				Jan 2	Day	2004	9:05a м
}	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, To	own, or Loca	ation of Death		4c.	County of Deat	h
			443 Shirley Ma	nor Road		Re	ister	rstown			Balti	.more
	Funeral		5. Social Security Number 6. Sex	M OFF	. last birthday)	If Under 1 Months		Jnder 24 Hrs. ours Min.	8. Date of Birt (Month, Da	h v, Year)	Co	hplace (State or Foreign
	Director		000-42-4413	6	3 Yrs.				Jan28,	194	0 Cze	ech Republi
	and	}	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
	f sho	ō	MD Bal	timore		В	altin	nore				to Yes 2 No
	the t	rect	10e. Street and Number	02010		10f. Zip C				10g. Citi	zen of What Co	ountry?
	3e or	Funeral Director	6810 Park Heig	hts Ave.			212	215		USA		
	deetl	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede	ent of Hispan	nic Origin? (Spi	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White	
9	or the	F	1 Never Married 2 Married	1 ∐Yes 2√MNo If Yes, Give		1 Yes 2		ecity:			Specify.Whi	
8	within 72 hours after deeth with the Maryland ene. than "natural", or Items 23e or 28e-f show ta Mudical Exami er must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:								
<u>7</u>	n 72 r	lete	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual kind of work DO NOT use	done during	g most of work	in <i>g</i>		nd of Business/	
2	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +	Doc		, , , , , ,			Ps	ycholo	gy
Maryland 21215-0036	be filed within 72 hours after deeth with the Marylan hal hygiene. Ad other than "natural", or flems 23a or 28e-f show event, If a Mudical Examter must be notified at	Be Co	17. Father's Name (First, Middle, Last)				18.	Mother's Name	e (First, Middle,	Maiden	Sumame)	
a	should be ad Mental marked c matic eve	To B	unknown					unkno	wn			
ary	A DEE		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ing Address (Street and A	Number or Rura	al Route Numbe	er, City o	Town, State, 2	Zip Code)
	1 and 2 Health a em 27 is		Jason Beran /	son				and the second second second second	Randa			
ore	ges 1 a it of Hea if Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	Place of Dispo cemetery, cre.	matory or oth	ner place)	1/31	/ 0.4		cation - City or	
Ë	Pages ment of ant: If It		*4 □ Donation 5 □ Other (Specify)	В	ayvie		_	7			timore	
Baltimore,	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service License		, 2	2. Name and	Address of	Facility Con	nelly	une	ralHom	neofEssex
	40364		23a. Part1. Enter the disease, or oppopli	annelle	-1	300	Mace	Ave.	Baltin	ore	MD 21	221 Approximate
			shock, or heart failure. List only on	e cause on each line:						1031,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		SDIAL	- IN	11112	CTIO	10			
gs.	Examiner			Due to (or as a conse		PTE	PY	D158	ASE			
	4	er	Sequentially list conditions, if any, leading to immediate cause. Enter Undertrying Cause (Disease or injury	Due to (or as a conse		10,0	15/	0.00	ے در، ر			
	od ansit	Examiner	that initiated events									
o,	sicien and burial-transit		resulting in death) Last	Due to (or as a conse	equence of):							
3760,	- × 9	Ical		l								
89)	death certificate be attending physic	Med	IF FEMALE:									
Вох	ath ce ttend or use	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	⊒Ectopic pre				1	23d. Date of del Month	livery Day Year
0		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5	Other (spe	сту)					
α.	that the ed by detac		Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	underlying ca	use given in	Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
Records,	The law requires that the tite has been signed by the bage 2 should be detached.	d by							10	res 21	□No 3□Pr	robably 4 Unknown
CO	w requir been si should	Completed							24a. Was	an	24b. Were au	utopsy findings available
Re	The lay	m d m								rmed?	prior to death?	completion of cause of 2 ☐ No
Vital		C	25. Was case referred to medical		<u>.</u>		26.	Place of Deat	1 Yes	2. No ne)	1 103	2 110
>	d S	OB	examiner? 1 No 1 No H	fospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DO	Other: 4	Nursing Ho	me 5 Resi	dence (Sther (Spe	cify)
υot	ng Ph ter th	n: T	27. Menner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28	c. Injury at Work?		28d. Describe	now injur	y occurred	
<u>0</u>	Attending r death. sctor: After by the fune	atic	2 Accident investigation			М	1 🗆 Yes					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec		treet, factory,	office		28f. Location (. City or To			ural Route Number,
	Hospitel (24 hours a Funeral Ditely filled i		20s Codifice 1 Codificing Phys	nicion. To the best of much	noulades das	th conversed a	the time d	late and place	and due to the	221120(2)	and manner 20	stated
I	ne Hospitel or Attending P n 24 hours after death. ne Funeral Director: After the	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my kiner: On the basis of examinand manner stated.	nation and/or in	nvestigation,	in my opinioi	n, death occur	red at the time,	date and	place, and due	o to the cause(s)
ζ	To the Hos within 24 h To the Fur completely	₹ E	29b. Signature and title of certifier				License nur				e signed (Mont	
			* Moulesco	fromo.	MD	D	38:	363		1-	30-	2004
	20		30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type	Print)	110	INDIE	0 6	TO	wcn,	
_	σ		FRANCESCO G			04	IV & CH	HRUC) 21	10		
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature							
	Regist	rar	ccs 0 3 2004	Reserve St.	1	-						

			For State Ragistrar	State of Ma	iryianu		tificate of			g. No.	UH	U2/64
	DI		Decedent's Name (First, Middle, Last)						2. Date of Death Month		Year	3. Time of Death
A.	Physicia /Medic			MELVIN E	DWARD	BARN			January	31, 20	004	10:35 p ^M
}	Examin	er	4a. Facility Name (If not institution, give s		1 0			r Location of Death		4c. County		1 1
			Crofton Convalesc 5. Social Security Number 6. Sex		(In yrs. las		Crofton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	-	Arun 9 Birtho	
est.	Funeral Director			M OF	85	Yrs.	Months Days	Hours Min.	(Month, Day, Nov 28,	1918	New New	lace (State or Foreign try) Jersey
	death with the Maryland rms 23e or 28e-f show r must be notified at	-	10a. State 10b. County		10c. City,	Town or Lo	cation				10	0d. Inside City Limits
	he M. 18e-f	Director	MD Anne Aru 10e. Street and Number	nde1	0den	ton	404 7:- Code		1.00	g. Citizen of V	Athat Caus	
	with t	古	2288 Snowfall Cou	L			10f. Zip Code 21113		10	U.S.A.		uyı
	Jeath In 23	Funeral		12. Was Decedent E	ver in U.S.	13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Rac	e - Americ	
	should be filed within 72 hours after death with the Marylan of Mental Hygiens. I marked other than "natural", or flems 23e or 28e-f show marked other than "natural", or leans 25e or 28e-f show marked other than "natural".	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 XYes 2 □ No lif Yes, Give Year or Dates: 1	o O/:/:_/		fYes, specify Cuba I□Yes 2∏XNo	Specify:	Rican, etc.)	Specify	white, white, white, white	
ş	2 hou	ted	15. Decedent's Educ	ation		16a. Deced	ent's Usual Occup	ation	. 1	6b. Kind of Bu		
212	thin 7. 9. Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	NOT use retired	during most of work d)	ing			
2	filed wit Hygiene ther the	Соп		2		Graph	ic Artis			Adverti		
Maryland 21215-0036	ild be filt lental Hy ked oth iic event	Be	17. Father's Name (First, Middle, Last)						e (First, Middle, M	aiden Suman	10)	
<u>Ş</u>	should ind Men marke umatic	2	Edward Barnes	0-i-4)		105 11-05-		Dorothy and Number or Rur		04	C4-4- 7:-	0.41
<u>a</u>	d 2 st th and 7 is n treun		19a. Informant's Name/Relationship (Ty) Christopher H. Ba					and Number of Hur l Court,				
	1 and Health Iem 27 Sthar tr		20a. Method of Disposition	11165 / 5011			sition (Name of natory or other place			Oc. Location -		
Ē	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State				ory Feb 2	, 2004 0	denton	, Mar	yland
Baltimore,	permit. Pages 1 and 2 should be Department of Headil and Mentia Important: If Item 27 is marked any injury or othar treumatic of Once.		21. Signature of Funeral Service Liberes	ne .	-	22 D	. Name and Addre	ss of Facility Funeral	Home & Ci	remator	ry, P	.A.
			23a. Part1. Enter the disease, or complishock, or realt failure. List only or	cations that caused	MO07 the death.			polis Roa			ylan	d 21113 Approximate Interval Between
)	Physician		Immediate Cause (Pinal disease or condition					vascular				Onset and Death Years
	/Medical Examiner		resulting in death)	Due to (or as a								
Н	LAGITITICI	1	Sequentially list conditions,	. Hype	ertens	sive (Cardiovas	cular Dis	sease			Years
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (01 43 4	Conseque	1100 01).						
,	execu in and ial-tra	Exal	resulting in death) Last	Due to (or as a	conseque	nce of):		- , , 				
68760,	icate be executed physician and s the burlal-transit	edicai										
89	entifica ing ph e as ti		IF FEMALE:				· · · · · · · · · · · · · · · · · · ·					
Box	leath certifi attending I for use as	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 ☐ Fetal d	eath 3	Ectopic pregnancy	,		23d. Dat Mo	e of delive	ry Day Year
О	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	lime or dea	tn 5∟	Other (specify)					
ت. ت	w requires that the di been signed by the should be detached	by Ph	Part II. Other significant conditions con	tributing to death bu	it not result	ing in the ur	nderlying cause giv	en in Part I.	23e. Did toba	acco use cont	ribute to th	e cause of death?
Vital Records,	quire: en sig uld be	q pa							1 ☐ Yes	2 No	3 Proba	ably 4 Unknown
ဝ္ပ	e law re has bee je 2 sho	piet							24a. Was an autopsy			osy findings available inpletion of cause of
ĭ	The ate h page	Completed							perform 1 ☐ Yes 2	ed? d □ No 1	death?	
ī a	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				la.		h (Check only one)		
5	Physic this c	2	1 ☐ Yes 2 No	ospital:		NOutpatien 8b. Time of		4 Nursing Ho	me 5 Resider)
C	ding I h. After funer	ion	1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 2	Injury	28c. Injur Wor M 1 🗆	yat k? Yes 2 □ No	28d. Describe how	v injury occurr	90	
Division of	or Attend after death Director: / d in by the f	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	iry - At hom . (Specify)	e, farm, stre		W-2011	28f. Location (Stre City or Town,	et and Numb State)	er or Rurai	l Route Number,
u	To the Hospital or Attending Physician: whith 24 hours after deals after deals To the Funeral Director. After this certification is the funeral director.		29a. Certifier 1 Certifying Physical Check only 2 Madical Examin	sician: To the best of	of my knowl	edge, death	occurred at the tir	ne, date and place,	and due to the car	use(s) and ma	nner as sta	ated.
	the H nin 24 the F the F	Medical	one)	and manner stat	ted.	ii anwoi iii						
	To To	-	29b. Signature and title of certifier	- C34 A	00	4 . 5	29c. Licens	2010	Ç 29	d. Date signed	(Month, L	⊅ay, rear) ∕
7	1		Makust	1000	119	MD		2010		-1.	40	1
	b		30. Name and address of person who co Rakesh Arora, MD	mpleted cause of de 14300 Ga				wie, Mary	land 210	35		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	re		,)				
	Registr		FFR 0.3	2004 ▶ 1	8.0	20	Acade 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AS State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 4:15A **Physician** Butterhoff Jr John Frederick January 28, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. September 5,1925 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 28/04/0 Funeral 1**X**XM 2□F 78 Director 217-20-6084 Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State ir than "naturel", or Itama 23a or 28a-f ehow the Medical Examinar must be notified at YYY Yes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 USA 5622 Sagra Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1XXYes 2 No Korea 1 Never Married 2 Married 1 Yes 2XNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedeni's Education (Specify only highest grade completed) 2121 Elementary/Secondary (0-12) College (1-4or 5+) Data Processor Oil Company 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any injury or other traumatic event Mary Emory John Frederick Butterhoff Sr ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 3029 California Avenue Baltimore, Maryland 21234 Mary B Ambrose Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 2/2/04 Greenmount Cemetery Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complimitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) Pulmonasy Physician /Medical Due to (or as a consequence of): Examiner Crastate Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and II-transit physicien ar s the burial-ti Due to (or as a consequence of): Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, 1 Yes 2 No 3 Probably as been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? page certificate 1□ Yes 25 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 98303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Challes of Baltimore MD 21209 AMA 32. Registrar's Signature 31. Date filed (Menth-Day) Year) 2004 State Registrar

DHMH 17 Rev 1/2001

S

			1 - For State Registrar	State of Maryland / [Department of Hea Certificate of De	Ith and Menta	-	2004	02766
T.	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Robert Brum 4a. Facility Name (If not institution, gives	1/ 1/	4b. City, Town, or Loca		ite of Death onth Da	y Year	3. Time of Death
	Funeral Director		5. Social Security Number 6. Şex	AL OFF		Under 24 Hrs. 8. Da	ite of Birth lonth, Day, Year)	N/A 9. Birthpl Count Mary	ace (State or Foreign ry) 1and
	nii. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ardment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a Madical Examinar must be notified at injury or other traumatic event, it a Madical Examinar must be notified at	by Funeral Director	10a. State 10b. County Maryland Harford 10e. Street and Number 315 Willrich Circl		est Hill 101. Zip Code 21 050			izen of What Count	od. Inside City Limits 1 Yes 2 No ry?
-0036	hours after death tural', or items 2 al Examinar mu	ed by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispan If Yes, specify Cuban, Mi 1 ☐ Yes 2 🛣 No Sp	pecify:	es or No- etc.)	USA 14. Race - America Black, White, e Specify: Whi	te
nd 21215-0036	a filed within 72. I Hygiene. other than "net	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) BINTER 18.	g most of working Mother's Name (First,	Ba: Boa	ind of Business/Ind ltimore C ard of Ed Sumame)	ounty
, Maryland	and 2 should be leath and Mental m 27 is marked of her traumatic even	ToB	Marion F. Brumfie 19a Informant's Name/Relationship (Tyr. Mildred C. Brumfie	pe, Print) 19b.	Mailing Address (Street and A		e Number, City o		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify) 21. Signature of Fureral Society is ense	emoval from State 20b. Place of cemeter West N	Disposition (Name of y, crematory or other place) lottingham Cem 22. Name and Address of	Date . 2/2/04	20c. Lo	ocation - City or Tov ora Mary 1050 Yor	vn, State land
	permi		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cation hat caused the death. Do not be capted on each line.	Ruck Towson F				Md. 21204 Approximate Interval Between Onset and Death
8760,	/Medical Examiner Asician and privial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	of):			100	11 May
.O. Box 6	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specity)			23d. Date of delivery	y Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions cont	tributing to death but not resulting in	the underlying cause given in i	Part I. 23		se contribute to the	cause of death?
Vital Rec		Be Completed	25. Was case referred to medical examiner?		26.		a. Was an autopsy performed? Yes 2 No	24b. Were autops prior to com death? 1 Yes 2	sy findings available pletion of cause of
Division of V	ding Phys). After this funeral dia	Certification: To F	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ime of 28c. Injury at jury Work? M 1 ☐ Yes		☐ Residence 6 escribe how injury		
DIV	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical Certifi	4 Homicide determined 29a. Certifier Check only 2 Medical Examin	28e. Place of Injury - At home, far building, etc. (Specify) cian: To the best of my knowledge er: On the basis of examination and	death occurred at the time, da	City	y or Town, State,	and manner as stal	ind
•	To the Ho within 24 To the Fu completel	Medi	29b. Signature and title of certifier	h As	29c. License num	<u> </u>		e signed (Month, Di	
	Sta Registr		30. Name and address of person who con famourta. A 31. Date liled (Month, Day, Year)	noleted cause of death (Item 23a) (och a Son och 32. Registrar's Signaure	Type, Print) Rava Sard &	Baltimore,	Marefas	A 21239	?

			State	of Maryland				-		•	
			1 - State Registrar	or Maryland /	•	cate of D				2004	02767
			Hegistrar 1. Decedent's Name (First, Middle, Last)		OCILIII	cate of D		2. Date of Dea	eg. No.		3. Time of Death
	Physicia		Harold H. Burns, M.D.					January	24	, 2004	11:20 PM
97	/Medic Examin		4a. Facility Name (If not institution, give street and	number)	4b	. City, Town, or L	ocation of Death			County of Death	1 1 1
			502 Hampton Lane		To	wson			Ba	ltimore	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	Mo		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Jan. 21,	Year)	Cour	lace (State or Foreign
	Director		214-20-3035	95	Yrs.			Jan. 21,	19	09 Penns	ýlvania
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location	on				1	0d. Inside City Limits
	Many -(sh	tor	MD Baltimore	Towsor	1						1 ☐ Yes 2 🔀 No
	r 28s	Director	10e. Street and Number			Of. Zip Code		1	0g. Citiz	en of What Cour	ntry?
	be filed within 72 hours after death with the Maryland tal Hyglene. A of other then "natural", or items 23a or 28a-f show of other then "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	alD	502 Hampton Lane			21286		l	JSA		
	r dea	by Funeral	Armed	ecedent Ever in U.S. Forces?	13. Was	Decedent of Hisp s, specify Cuban,	anic Origin? (S) Mexican, Puert	pecify Yes or No- o Rican, etc.)	1	 Race - Americ Black, White, 	
36	or it	y F.	If Yes.	s 2⊠No Give	10	Yes 2X No	Specify:			Specify:	hi+a
Ö	hour fural	ed b	15. Decedent's Education	r Dates:	6a. Decedent	s Usual Occupation	on.		16b Kin	d of Business/Ind	hite
7.	n "na	piet	(Specify only highest grade complete	d)	(Give kind life. DO l	of work done dui IOT use retired)	ring most of wor	king	100.14		200.19
212	d with	Completed	Elementary/Secondary (0-12) College 12	5+ St	urgeon/	General	Practit	tioner N	1edi	cine	
b	al Hyg	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle, i		Sumame)	
<u>ya</u>	Menti Menti arked	To	John F. Burns					L. Mulli	-		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if item 27 is marked other than "natural", or items 23a or 28a-1 ahow my injury or other treumatic event, it is Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Harold H. Burns, Jr. /	con				ral Route Number			21202
e)	1 and Health Bm 27 ther tr		20a. Method of Disposition				on Stree	et suite		; Baltim cation - City or To	
Jor	Pages nent of I nnt: If it		1 ⊠ Bunal 2 ☐ Cremation 3 ☐ Removal fro	m State		n (Name of ry or other place)	1/21				
	artme ortan injury		4 □Donation 5 □ Other (Specify) 21. Signature of Pyneral Service Licensee	фитапеу		Mem Garde		04		nium, MD 50 York	
Ba	permit. Departr Importa any inju		De Val			Towson		Home		wson, MD	
			23a. Part1. Enter the disease, or complications has shock, or heart failure. List only one cays of	at caused the death. D	_						Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	Musl	oda	SPE	Astro	SUNK	no.	ME	Onset and Death
	/Medical		resulting in death)	to (or as a consequent	ce of):	9-11					7,000-2
	Examiner		Sequentially list conditions, b								
10.00	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequent	ce of):						
/	and and II-tran	хаг	that initiated events c	to (or as a consequent	ce of):						
760,	eath certificate be executed attending physician and for use as the burial-transit	calE									
89			U								
Вох	andin use	M/M		outcome of pregnancy e birth 2 Fetal dea		opic pregnancy			2	3d. Date of delive	
	Attending Physicien: The law requires that the death certifica codealh. croor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	1 Yes 2 No	agnant at time of death		ner (specify)				Month	Day Year
о. О.	at the	Phy	9 Duknown					ODa Didani			and the state of t
S,	res th	by	Part II. Other significant conditions contributing to	death but not resulting	g in the under	ying cause given	in Part I.	1 Y			ne cause of death? abiy 4 ∐Unknown
Vital Records,	w require been sign	Completed	Corinary Ante	Mis Da	24 A A	5				1	
3ec	e law has b	Idu	(,)	1 60	11001	<u>C</u>		24a. Was a autops perform	У	prior to cor death?	psy findings available apletion of cause of
a	n: Th ficate r, pag		or Wasses of section of the last					1 □ Yes	No	1 🗆 Yes	2□ No
	sician: The law certificate has b irector, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	□Inpatient 2□ER/	Outpatient 3	DOA Other:		th (Check only of		Cothas (Cossit	4
of	Phy ar this aral d	n: To	27. Manper of Death 28a. Da	ite of Injury 281	b. Time of	28c. Injury a	4 Li Nursing n	ome 5 Reside	_		<i>'</i>
<u>o</u>	ath. r: Afte e fun	atio	1 Natural 5 □ Pending (M 2 □ Accident investigation	lonth, Day Year)	Injury I	Work? I∐Ye	s 2 No				
Division of	er des recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Pla	ace of Injury - At home, ilding, etc. (Specify)	, farm, street,	factory, office		28f. Location (St City or Town	reet and	Number or Rura	l Route Number,
Ō	ital ours aft ral Di										
	To the Hospital or Attending Physician: The within 24 burs after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only 1 Certifying Physician: To Check only Certifying Physician: To	a basis of examination	dge, death occ and/or investi	curred at the time, gation, in my opin	date and place ion, death occu	, and due to the carred at the time, d	ause(s) a ate and	and m <i>a</i> nner as st place, and due to	ated. the cause(s)
	othe ithin 2 o the	Med	one) and m 29b. Signature and title oncentrier	anner stated.		29c. License r	number	2	9d. Date	signed (Month,	Day, Year)
	F ≱ F 8		AMMI	Mr. V.	W	D2	369.4	4	1/2	27/04	/
	12		30. Name and address of person who completed on	ause of death (Item 23	a) (Type, Prin	1)	ノマル		1	1 - /	
	10		1	Osler Driv			Towson,	MD 2120	4		
10	Sta			. Registrar's ignature	K	Last.	,				

Ernest Burke 04-0844 **AKG**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1844		1 - For Unpend I	tem i	#23ate29	y Maryla	ned 6824	astment of l	lealth Death	and M	lental Hy	giene 2 0	04	02768
		Decedent's Name (First, M							-	2. Date of Dea	ath		3. Time of Death
Physicia /Medic		Ernest A.	Bu	rke						Month Januar	Day V 31. 2	_{Үөаг} 2004	9:55 P ^M
Examin		4a. Facility Name (If not institu	tion, give	street and nu	mber)		4b. City, Town, o	r Location	of Death		4c. Count	y of Deeth	
		Good Samarita	an Ho	spital			Baltimo				n/a		
Funeral Director		5. Social Security Number 215-16-5280	6. Se	X M 2□F	7. Age (In y	rs. last birthda Yrs.	y) If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Birt (Month, Dat June 26	y, Year)	Cour	place (State or Foreign ntry) BIV1and
		Usual Residence of Decedent			, ,						,		
ylan		10a. State 10b. Cou	nty		10c.	City, Town or	Location					1	10d. Inside City Limits
B-f-	cto	MD Bal	timo	re		Pikes	/ille						1 ☐ Yes 2 X No
or 28)ire	10e. Street and Number					10f. Zip Code				10g. Citizen of	What Coul	ntry?
238	ral	9050 Iron Ho	rse	Lane			21208				Unite		
tams	Funeral Director	11. Marital Status		12. Was Dec Armed Fo	orces?		 Was Decedent of H If Yes, specify Cuba 	lispanic C an, Mexic	origin? (Spo an, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ick, White,	
s afte	by Fi	1 ☐ Never Married 2 🔀 I 3 ☐ Widowed 4 ☐ Divor		1 [X]Yes If Yes, Gi Year or D	2 □ No U ve	m TT	1 ☐ Yes 2 💢 No	Specif	y:		Speci	ý: B.	lack
hour	edt		dent's Edu			16a, Dec	cedent's Usual Occup	ation			16b. Kind of E	Jusiness/Ir	ndustry
n n	plet	(Specify only his Elementary/Secondary (0-1	hest grad			(Gi life	ve kind of work done . DO NOT use retired	during mo d)	ost of work	ing			
d with	Completed	7	2,	College (19401 347		Athlete				Lect	urer	
al Hy f oth	Be	17. Father's Name (First, Mid	de, Last)					_		e (First, Middle,		ne)	
and 2 should be filed within 72 hours after death with the Maryland bealth and Mental Hygiene. In 27 is marked other then "natural", or itams 23s or 28s-f show her traumatic event, the Medical Examiner must be notilized	2	Unknown		Unkno	ML			Te	resa	Mitch	ell		
2 sh and 1s m		19a. Informant's Name/Relat					iling Address (Street						
1 and Health em 27		Sandra Burke 20a. Method of Disposition	e/WlT	e	201		50 Iron Ho				ille, M		1208 Own State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23s or 28s-1 show eny injury or other traumatic event, the Medical Experient must be notified at once.		1 X Burial 2 ☐ Cremati			State	cemetery, c	rematory or other place		_	72004			
it. Partmen		. 4 □Donation 5 □ Othe 21. Signature of Funeral Sen			تا ا		n Forest V			Junk Tou	Pikes\		, MD Home, Inc.
permit. Departn Imports eny inju		1.100	1	2			1050 Yor			owson,			1204
- 5		23a. Part1. Enter the disease	, or comp	lications that	caused the d	eath. Do not e							Approximate Interval Between
Physician		shock, or heart failure. Immediate Cause (Final	List only o			C		Comn	licat	iona			Onset and Death
/Medical		disease or condition resulting in death)	-			carcii sequence of):	noma with	COMP.	TTCat	TOIIS			
Examiner		Constitution that are distant	-	b									
D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to	(or as a cons	sequence of):			-				
and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c	(25.55.5.55.5	2000000 041							
cate be executed physician and the burial-transit	al E	,		D00 (0	(or as a cons	sequence of):							
The law requires that the death certilicate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	dical			d									
eath certific attending p	/Me	IF FEMALE:		23c. If yes, ou	tcome of pre-	gnancy					23d, Da	ate of delive	erv
death atter	Physician/Me	in the past 12 months?			binth 2□F nantattime o		I □Ectopic pregnancy □ Other (specify) _	/				onth	Day Year
at the de by the a tached	hys	9 □ Unknown		9□ Unkr	nown								
w requires that been signed E should be deta	ЬγР	Part II. Other significant con	ditions co	entributing to o	leath but not	resulting in the	underlying cause giv	en in Pari	t I.	23e. Did to	obacco use con	tribute to t	he cause of death?
en sig										101	res 2□No	3 Prot	bably 4 P nknown
has be	Completed									24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of
sician: The la certificate ha irector, page 3	Con										rmed? 2 ☐ No	death?	2 □ No
ysician: is certific director,	Be	25. Was case referred to me- examiner?		Hospital:			Oth	00		h (Check only o		/	
this ald	. To	1 ∑Yes 2 ☐ No 27. Manner of Death		28a. Date	-	2 ER/Outpat 28b. Time	mai is	4 🗆 1		me 5 Resid			fy)
ding h. After fune	tlon	1 Natural 5 Pe	nding estigation	(Mor	nth, Day Year) Injun	/ Wor	k?` Yes 2[200. 20001100 1	iow injury book	100	
Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Co	uld not be	286. Plac	e of Injury - A	it home, farm,	street, factory, office					ber or Run	al Route Number,
s after	Certification:	4 Homicide		build	ling, etc. (Spe	ecity)				City or Tou	vn, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (iner: On the b			ath occurred at the tir investigation, in my o						
ompl	Me	29b. Signature and title of ce	tifier				29c. Licens	e number	r		29d. Date sign	ed (Month,	Day, Year)
, , , ,		1 Theod	- par	1 16		m	O.C.M	1.E.			Februa	ary 1	, 2004
		30. Name and address of per	son who o	completed cau	s of both (Item 23a) (Typ	e, Print)		,			_	
		MEDOORE.	u. K.	4		- 3	111 Pe	enn S	treet	, Balti	more, M	4aryl	and 21201
Sta		31. Date filed (Month, Day, Y	ear)	32.1	Registrar's Si	gure	I Apo	. 00 2					
Registr	ar		FE	3032	5 U4		No Page	1					

DHMH 17 Rev 1/2001

ORIGINAL

1112	1	For Unpend Item#23 State Registrar 1. Decedent's Name (First, Middle, Lasi			Cei	Titicate	e or L	Jeath		2. Date of De.	3	. C. U	UH	UZID
Physician	1	VICTORIA L		N						Month JANUAI		Ď, 2	Year 004	3. Time of Death 4:35 P
/Medical Examiner		ta. Facility Name (If not institution, give				4b. City,	Town, or	Location of	f Death			County		1.33 1
		10610 LAKE SPRI	NG WAY					SVILL				BALT	IMOR	E CO
Funeral Director		212-90-2242	× 7. Ag	ge (In yrs. Ia 26	st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min,	B. Date of Birt (Month, Da April	6,1	977	9. Birthy Coul Mary	place (State or Foreig ntry) Y Land
land ow	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation							1.	10d. Inside City Limits
Many Many	5	Maryland Baltimon	e e	Coc	keysvi	.11e								1 ☐ Yes 2 ☐ No
death with the Maryland ms 23a or 28a-f show trivial be notified at		10e. Street and Number				10f. Zip					10g. Cit	izen of W	hat Cou	ntry?
s 23a	8	10610 Lake Spring		- · · · · ·			.030					S.A.		
or its	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 MDivorced	12. Was Decedent Armed Forces? 1 Yes 2 St If Yes, Give X Year or Dates:		'	f Yes, spec	ify Cuba	spanic Origin, Mexican Specify:	jin / (Spe , Puerto	ecify Yes or No Rican, etc.)		Blaci	White,	
2 should be filed within 72 hours and Mental Hygiene. is marked other than "natural; raumatic event, the Modical Ext. To Be Completed by		15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usua kind of wor	l Occupa	ition	of worki	na	16b. K	ind of Bu	siness/In	dustry
within ene.		Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT us	e retired,)	Or WORK!	ng		.,		
Hygie Other t ent, in		12 17. Father's Name (First, Middle, Last)				Sir	nger	18. Mothe	r's Name	(First, Middle,	Maiden	Musi		
Mental Mental Mrked o atto eve	ונ	George		Bur	ton			Sara	_	(*, *			nes	
shou and N		19a. Informant's Name/Relationship (T)								l Route Numbe	er, City o			Code)
and 2 ealth m 27 her tra	-	· · · · · · · · · · · · · · · · · · ·	ather)		10610			ing V	_					and 21030
permit. Pages 1 and 1 Department of Health Important: If Item 27 eny injury or other tr once.	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Dul	nce of Dispo metery, crep aney	sition (Nam natory or ot Valle	ne of ther place y MEI	m.Gdns	.2/3/	O4 I		ium, M	•	own, State nd
Departition Depart		21. Signature of Funeral Service Licens	Brat		22	Vitche 65W	Addres LL-Wi YOCK	s of Facility edefelo kd. ba	d F.H Ltimo	.Inc. re,Maryla	and 2	1212		
Physician /Medical Examiner		f any leading to immediate	Narcotic Due to (or as	ne. Intoxi a conseque	cation ence of):									Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):									
that the death certificated by the attending plateached for use as the physician/Med		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Winknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3 ☐	Ectopic pre					4	23d. Date Mon		ory Day Year
w requires that the been signed by the should be detach should by the letech by Phy	ו ו	Part II. Other significant conditions con	ntributing to death b	ut not resul	ting in the ur	iderlying ca	use give	n in Part I.		23e. Did to		_/		ne cause of death? ably 4 □Unknown
The law requir	-									24a. Was a autop: perfor	sy	pr de	ior to cor ath?	psy findings available npletion of cause of
Physician: rthis certificaral director, TO Be C		25. Was case referred to medical examiner?	lospital:				Otha		of Death	(Check only or	16)			
ding Physician: The lav. After this certificate has funeral director, page 2 tlon; To Be Comp		1 X Yes 2 No	1 Inpatie	DV S	R/Outpatien 28b. Time of Injury 4:30	28	c. Injury Work	4 🗀 14u1	2	ne 5 🗆 Resid 8d. Describe h		Other occurre		SCENE
To the Hospital or Attending P within 24 hours after death or To the Funeral Director. Aller I completely filled in by the funeral Medical Certification;		3 Suicide 6 A Could not be determined	28e. Place of Inju Found at	ury - At hon	Loun ne, farm, stre					8f. Location (S City or Town	n, State,)		I Route Number,
thin 24 hours thin 24 hours the Funeral impletely fille		29a. Certifier 1 ☐ Certifying Physical Conduction 1 ☐ Certifying Physical Examination (Chack only one)	sician: To the best of ner: On the basis of and manner sta	r examinatio	ledge, death on and/or inv	occurred a estigation,	t the time in my op:	e, date and inion, death	place, a	nd due to the c	auso/e	and man	nor ac et	atod
To the within To the comp	1 2	29b. Sichature and title of certifier.	eShel	e M	N)		License C N					_		2004
	١	10. Name and addr ss of person who co	KORE	w			ll Pe	enn S	tree	t, Balt	imor	æ, M	[ary]	land 21201
State Registrar		FFR (13 2004	32. Registra			rocks								

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For AMEND ITEM 20b, per Registrar	State of Ma r FH,G828,2/	ryland / /3/04,00	Depa Cer	irtment <i>tificate</i>	of H	ealth and Death	Mental Hy	giene Reg. No.	2004	027	70
			Decedent's Name (First, Middle, Last)							2. Date of De		Vaar	3. Time of Dea	
	Physici /Medic		Robert Edward Cough	hlan, III						Jane		0 200L	11:301	4 м
	Examin		4a. Fecility Name (If not institution, give s	street and number)			4b. City, To	own, or	Location of Dea	th	40 Cour	nty of Death		
			St. Agnes Hea	alth ca	re				noce		N/A	Α		
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last l	, ,	If Under 1 Months	Year Days	If Under 24 Hrs Hours Min		th ly, Year)	9. Birthp	place (State or Fo	reign
(E.	Director		213-28-9848		74	Yrs.				March	28 1929	9 MD		
	and w	}	Usuel Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					1	10d. Inside City Li	imits
	Manyl f sho	ō	7 1 1		Cat		41 1 a						1 □ Yes 2 0	N o
	28a-	Director	MD Baltimo: 10e. Street and Number	re	Cat	onsv:	10f. Zip 0	Code			10g. Citizen o	of What Cour	ntry?	
	3a or		1207 History Assessed						21220		77.0	C A		
	ms 2;	era	1307 Hubner Avenue	12. Was Decedent E	ver in U.S.	13. V	Vas Decede	nt of Hi	21228 ispanic Origin? (Specify Yes or No	- 14. F	SA Race - Americ		
9	or Ite	by Funeral	1 ☐ Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give	°Korea:	n i			n, Mexican, Puer	to Hican, etc.)		Black, White,	etc.	
8	ral', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	War		I□Yes 2∫	INO	Specify:		Spe	cify:	White	
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show ther, the Medical Exardinar results rediffed at	Completed	15. Decedent's Educ (Specify only highest grade	cation a completed)	16	(Give	lent's Usual kind of work	done d	during most of wo	rking	16b. Kind of	f Business/In	dustry	
2	hen.	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	+)		DO NOT use						- 1	
	lled v tygie her t	ပ္ပ	12 17. Father's Name (First, Middle, Last)	4		Com	pensat	ion	Manage:	me (First Middle			ng Indus	stry
anc	ntal h	Be		-					Unknown	me (First, Middle	, 17/4/36/1 (34/1)	u		
Maryland	should ad Me mark matic	<u>٢</u>	Robert E. Coughla:		15	9b. Mailin	a Address (Street a	and Number or R	ural Route Numb	er. City or Toy	wn. State. Zic	Code)	
∑	nd 2 s Ith ar 27 is r trau		Carol Coughlan/Wife			1307	Hubne	or A	venue]	Baltimor	e MD 1	21228	,	
ē,	f Healifem		20a. Method of Disposition		20b. Place	of Dispos	sition (Name natory or oth	e of		Date	_	on - City or To	own, State	
e E	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Balto.					3/2004 32/2004	Lour	el. MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examinar results to include at an angle.		21. Signature of Funeral Service	4	marto					nwab Fun				
m	Dep Impo		Fur Letait	U						Baltim			8	
	do.		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. D	o not ente	er the mode	of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between	n
S.	Physician		Immediate Cause (Final disease or condition	5/57	060								Onset and Deat	th
48	/Medical		resulting in death)	Due to (or as a	consequenc	e of):							·	
	Examiner	. 1	Sequentially list conditions,	Pni	mul	OY	nd					-	clary)
	D #	Examiner	if any, leading to immediate	Due to (ar as a	consequenc	e (1):	. 0						, 0	
	and -trans	Kam	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	ema	9.00):	anli	w					days	
8760,	cate be executed ohysician and the burial-transit	ai E			Consequence	A 0	Deni	1	Fail	uD1			dan	
387		dicai		Cong	esun	/ U	13.00	4	1 0000				cherry	<u>'</u>
×	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o							23d. I	Date of delive	erv	
Вох	death atter	ciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic pred Other <i>(spe</i> d					Month	Day Year	
o	the c	hysi	9 Unknown	9 Unknown										
ď	res that igned to be det	y P	Part II. Other significant conditions cor	tributing to death bu	t not resulting	in the ur	nderlying cau	use give	en in Part I.	23e. Did	obacco use co	ontribute to th	he cause of death	1?
ğ	v require been sig should b									1 🗆	Yes 2□No	3 ☐ Prob	oably 4 ∐Unkn	nown
CG	e law requ has been je 2 shouł	piet								24a. Was		b. Were auto	ppsy findings avail	iable
Ä	The I	Completed								perfo	ormed?	death?		, 01
Vital Records,	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?							ath (Check only	one)			
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ No	lospital: 1 Impatier		_	t 3 DOA		4 Norsing i	Home 5 ☐ Resi			ý)	
n	ding P h. After t funera	on:	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day		. Time of Injury		c. Injury Work		28d. Describe	how injury occ	urred:		
Sio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	On Blace of lain	a. Athana	form str	M		Yes 2 □ No	29f Logstine	Ctroot and Mu	-hou or Our	J. Clauda Mumban	- 115
Division	l or Attendater deat Director:	Certification:	4 Homicide determined	28e. Place of Inju building, etc.	. (Specify)	tarm, str	eet, ractory,	OTTICE		City or To	wn, State)	mber or Hura	al Route Number,	
_	ppitel ours a		29a. Certifier 1 Cartifying Phys	sician: To the best o	of my knowled	ge death	occurred at	t the tim	ne date and place	and due to the	cause(s) and	manner as s	tated.	
-	To the Hospitel or Attent within 24 hours after deall To the Funeral Director: completely filled in by the	edical		ner: On the basis of and manner stat	examination :									
X	To th To th Comp	Me	29b. Signature and title of certifier	1 2			29c.	License	number	1 +	29d. Date sig	ned (Month,	Day, Year)	1.1
4	*		> Syoury, N	1.1)			Do	00	6080	1	Janu	ww.	30,200	341
	10		30. Name and address of person who co	impleted cause of de	eath (Item 23a	(Type	Print)		R ATT.	inner	. 100) 91:	ワッカ	
			31 Date filed (About have your	900 (alor	V1.	the) all	MAN	1/1/	1 11	4	
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 3 200	32. Hegistra	r's Signature		RIGHT							

			For State Registrar		State o	f Maryla	and / Depa <i>Ce</i>			lealth a D <i>eath</i>	nd Me		iene eg. No.	200	4 (2771
			1. Decedent's Name (First, Middle	e, Last)	-		-				1	2. Date of Deat	th Day	Yeer		ime of Death
	Physici /Medio		Michael L. Col	lins	. Sr.						1	FEB	01	203	- 100	12 M
	Examir		4a. Facility Name (If not institution					4b. City,	Town, or	Location of			4c.	County of De	ath	
			ST AGNES	HE	ALT	HCA	RE	B	AL:	778	10 V	JE.		N/A		
	Funeral		5. Social Security Number	6. Sex			rs. last birthday)	If Under	r 1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day)	Yearl	9. B	irthplece (State or Foreign
2	Director		215-28-5841	1四	M 2□F	71	Yrs.	Montris	Days	Hours		05/28/1	932		MD	
	P .		Usual Residence of Decedent													
	urylar thow		10a. State 10b. County			100.	City, Town or Lo	ocation								side City Limits
	Ba-f.	ct	MD Balt	imor	e		Catons	ville	9							⊒Yes 2. No
	or 2	Director	10e. Street and Number					10f. Zip	Code			1	0g. Citia	zen of What C	Country?	
	23a		75 Garden Ridge							21228	· · · · · · ·				SA	
	er de	Funeral	11. Marital Status		Armed F		U.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Orig n, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)	1	14. Race - Am Black, Wh		lian,
36	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Midfral Exercities must be notified at	by Fu	1 Never Married 2 Married		If Yes, Gi	2 □ No ve		1 🗆 Yes	2 X No	Specify:				Specify:		r 77
8	urai	q p	3 Widowed 4 Divorced		Year or C	ates:							121 151			White
5	nat	Completed	15. Deceden (Specify only highe				16a. Dece (Give	kind of wa	ar Occupa	ation du <i>ring most</i> l)	of working	9	16b. Kir	nd of Busines	s/industry	
12	withir noe. Ihan	ם	Elementary/Secondary (0-12)		College (1-4or 5+)							ъ.	. 1		
22	Hygie Ther nt, III		12 17. Father's Name (First, Middle,	Last)	5+			chool	rea		r's Name /	First, Middle, I		altimo: Sumame)	re co	шису
ano	ntal led o	Be														
Š	hould d Me mark matic	ဥ	James A. Collin		a Print)		19h Maili	na Address	: (Street			ellor Route Number	City or	Town State	Zin Code	1
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examire crimal tennolitied at			, , ,,		155										
e, l	1 am Healt em 2 ther		Bertha W. Kerze	T-C0	TIINS	/ 20t	. Place of Dispo	sition (Na	me of	ge RD	_ ва. Da	ltimore	-	cation - City o		ete
20	iges in tof f		1 Burial 2 Cremation		gloy from	State G	cemetery, crea	matory or o	ther places t	θ)				,		
ij	t. Pa tmer tent tjury		4 ☑ Donation /5 ☐ Other (\$	-	111		eteran	Cemet	ery	0				ngs Mil		MD
Baltimore,	permit. Pages 1 an Department of Heali Importent: If Item 2 any injury or other once.		21. Signaturer of Funeral Service	Licens	1	7						ab Fune				
	40240	-	The state of the s) 4	0							Baltimo		MD 212		
Е			23a. Part1. Enter the disease, of shock, or heart failure. List	only one	cause on	each line.	eath. Do not en	er the mod	se or ayını	g, such as o	cardiac or	respiratory arre	est,		Interv	oximate val Between t and Death
	Physician		Immediate Cause (Final disease or condition	_ a.	_ {	h el	anna	wi	0						Do	B
п	/Medical Examiner		resulting in death)		Due to	(or as a cons	sequence of):	^	N						8	
я	A		Sequentially list conditions,	b	V2	Lev	~~!	+	en 1	Mr.	6				V N	~1.
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į	Due to	(or as a cons	sequence of):	× 00		~ i	200	= x 7			Λα.	()
	ecute and trans	Ше	that initiated events resulting in death) Last	c.	140	(or as a cons	170	- K	ベハ	Z r	$\mathcal{M}_{\mathcal{N}}$	viz h	OV	V D	INCO	myrch
50,	icate be executed physician and s the burial-transit	E	,		D08 10	(DI &S & COIIS	equence or,									
8760,	ate b	dlcal		d.		_ .										
9	n certific anding p use as	Me	IF FEMALE:	22	. 16											
Вох	death certifi e attending p ed for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23	1 Live	tcome of pred pirth 2 . F	etal death 3	Ectopic p					2	3d. Date of de Month	elivery Day	Year
0	the de	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Preg 9□Unkr	nant at time o	of death 5L	Other (sp	oecify)							
a.	that the de led by the detached	Physician/Me	Part II. Other significant conditi	ane cont	ributing to c	looth but not	rogulting in the u	adarbina c		on in Bart I		22a Did tot	22000 110	se contribute	to the cau	an of death?
ŝ	og De	þ	Part II, Other Significant conditi	ons con	indusing to c	ioatii bui iioti	resulting in the d	indenying t	ause give	minran.			s 2		robably	4 Onknown
50	v requires been sign should be	Completed										10.16		140 201	TODADIY	- CONKIONII
ec	aw S b	ople.									-	24a. Was a autops	y	24b. Were a prior to	utopsy fin	dings available on of cause of
S	Th ate pag	00										perform	ned?	death? 1 ☐ Ye		
Division of Vital Records,	Physician: The this certiticate ral director, pag	Be (25. Was case referred to medica examiner?	l .	-					26. Place	of Death (Check only on	θ)			
Š	hysic his ce I dire	ပို	1 Yes 2 No	Ho	spital:	Impatient 2	□ EP/Outpatie	nt 3 D	Othe Othe	er: 4 ☐ Nur	sing Hom	e 5 🗆 Reside	nce 6	□Other (Sp.	ecity)	
0			27. Mann of Death ↑ atural 5 ☐ Pendir	na	28a. Date (Mor	of Injury th, Day Year,	28b. Time o Injury	f 2	28c. Injury Work	at	28	ld. Describe ho	w injury	occurred		
.00	Attending r death. actor: After by the fune	atle	2 Accident investi	gation				М	10	Yes 2□N	10					
Ξ	l or Attsnatter deatl Director:	ţįį	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Place build	of Injury - Ai	t home, farm, streetly)	reet, factor	y, office		28	If. Location (St. City or Town	reet and , State)	Number or F	Rural Route	e Number,
	To the Hospital or Attsnowibin 24 hours after death To the Funeral Director: completely filled in by the	Certification:														40 54-41
	Hospital 24 hours a Funeral E	edical	29a. Certifier Certifyii	ng Physi Examin	cian: To the	e best of my l	knowledge, deat ination and/or in	h occurred	at the tim	ne, date and	f place, an	d due to the ca	use(s)	and manner a	is stated.	ause(s)
X	To the Ho within 24 I	led	one)			ner stated.										
	To T To I	Σ	29b. Signature and title of certifie	r ΔΔ	6	١.	0001		c. License	number	P	2	9d. Date	signed (Mon	ith, Day, Y	ear)
,	(Sam	111	e at ?	المعا	Ce 5- 6	RNOT		1 1	6-	t 0.2	wh	10	, 2	403
	4		30. Name and address of person	who con					135	-24	2457-	TRESTO	1200		4001	21229
		-	Emmoni				sour	NV	MI	20	CH	Con	YV	4 BC	un	mare in
	Sta Registi	_	31. Date filed (Month, Day, Year)	2004		Registrar's Sig	gnature	aste !								

MI CHAFEL

いっしいい と

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February Margaret Cataldi 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore St. Elizabeth Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan 14 1905 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 🛣 F 99 Maryland 215-01-8655 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County th and Mental Hygiene. ? Is marked other than "natural", or Items 23s or 28s-1 ehow traumatic event, the Medical Exam ar must be notified at 1 ☐ Yes 2√ No Baltimore Director Maryland | Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21227 3320 Benson Avenue Funeral 14. Race - American Indian, Bfeck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2√ No Baltimore, Maryland 21215-0036 Specify: Specify: 2 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be t of Health and Mental If item 27 is marked o Teresa Lascala Salvatore Messini Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 110 West Road, Suite 201, Towson, Maryland 21204 Wayne T. Prem / Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) injury or 2/9/04 Baltimore, Maryland Loudon Park Cemetery permit. Page Department of Important: If any injury or once. 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Sign ture Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each fine. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3mmoths **Physician** /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Completed by Physiclan/Medical the as attending p for use as *IF FEMALE* 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 174eoporosis 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes 220 No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 dursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After thi 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the Funeral Director: opletely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after the Hospital 🕰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 f To the Ful (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contrier eompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Kschik 32. Registrar's Signature 31. Date filed (Month, Day, Year) FFB 0 3 2004 State Registrar

	1 - State Registrar				Cei	tificat	e of L	Death		lental Hy	Reg. No.		UH	0 4.0 1 1
Physician /Medical Examiner	Naomi Ru	th Cha	ney reet and numbe	r)		4b. City,	Town, or	Location o	f Death	2. Date of De Month Feb. 1	2004		'ear Death	3. Time of Death
Funeral	Stella Mar 5. Social Security Number	er 6. Sex		Age (In yrs. I		To If Under Months	WSON 1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bi (Month, D Jan. 1	rth ay, Year)	Balt	9. Birthpl Coun	Ce ace (State or Foreign try)
Director	215–12–000 Usual Residence of Dec 10a. State 10b		-X	81	Yrs.	cation				Jan. 1	1,192	23	Md.	0d. Inside City Limits
or 28a-f st	Md. 10e. Street and Number	Baltimor			Dunda.	Lk 101. Zip					10g. Citi	izen of Wh	at Coun	1 ☐ Yes 2/□No try?
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Exenders must be notified at	3 ☐ Widowed 4 ☐	2 Married	t Rd. 2. Was Deceder Armed Force 1 □ Yes 2 Note If Yes, Give Year or Date:	s? ŽINo	l l	Was Deced f Yes, spec 1 Yes			gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-	USA 14. Race Black, Specify:	White, 6	
21215-0036 ed within 72 hours att ygiene. for than "natural", or t, the Modical Exercit Completed by F	15. (Specify of Elementary/Secondar 6 yrs.	Decedent's Educ- nty highest grade y (0-12)	ation completed) College (1-40	r 5+)		dent's Usua kind of wo DO NOT us	rk done d se retired	ition furing most)	of worki	ing		ind of Busi	ness/Ind	lustry
Maryland 2 In 2 should be filed to 2 should be filed 27 is marked other traumatic event, il	Harry Ru	dasil						Ru	th	(First, Middle Selby				
e, Mar 1 and 2 sho Health and em 27 1s m ither traum	Jesse Ch	aney	_{e, Print)} husband	20b. P	19b. Mailir 3302 lace of Dispo emetery, crer	Sol	lers	Poin	t Rd	al Route Numb L. Dund Date	alk N		1222	
tin timer thant thant sjury	1 X Burial 2 □ Cr '4 □ Donation 5 □ 21. Signaturfē)of Funera	emation 3 Re Other (Specify)			Lawn	Cem.	nd Addres	s of Facilit	Feb. 200	4		Ltimo		
Dermi Departi Impo	23a. Part 1. Enter the di shock, or heart fail	isease or complic lure. List only one	ations that cause on each	ed the dear	. Do not ent	7110	Sol	lers	Poin	Home O t Rd. or respiratory	21222	nda±k 2		Approximate Interval Between Onset and Death
760, e be executed /Medical Examiner e buriat-transit cal Examiner	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlyin Cause (Disease or injur that initiated events resulting in death) Last	ſ ^a	Due to (or a	T CANC as a consequ as a consequ as a consequ	uence of): uence of):									
P.O. BOX 68 hat the death certificat but by the attending phy detached for use as th Physician/Medil		gnant hths?	ic. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr	2 ☐ Fetal at time of de	déath 3[eath 5[Ectopic pr Other (sp	ecify)	en in Part I.		23e. Did		23d. Date Monti	n	ry Day Year e cause of death?
Rec he law e has b age 2 si			-							24a. Wa auto per		24b. We	ere autop or to con ath?	ably 4 Unknown osy findings available npletion of cause of 2 No
on of Vita	25. Was case referred to examiner? 1 Yes 2 XNo	_	28a. Date of I		ER/Outpatier 28b. Time o Injury		28c. Injury Work	er: 4□ Nu	rsing Ho	n <i>(Check only</i> me 5 ☐ Res 28d. Describe	idence			HOSPICE
Division c ttal or Attending P tal or Attending P tal Director: Atter ted in by the funera	3 Suicide 6	Could not be determined	28e. Place of building,	Injury - At ho etc. (Specify		eet, factor	y, office				(Street an own, State		or Rura	l Route Number,
the Hospi hin 24 hou the Funer npletely fill	29a. Certifier 1 1 (Check only one) 2 29b. Signature and title	Certifying Phys Medical Examin		of examina		vestigation		oinion, dea			, date and	d piace, an	d due to	
To with	30. Name and address	(nolated cause of	of death (Item	23a) (Tyne		DY	377	25		2	2/2	10	4
10	DR. TARIO 31. Date filed (Month, D	MAHMOOD	2300	DULANE	Y VAL	EY R	D	TIMON	IUM,	MD 21	093			

DHMH 17 Rev 1/2001

FEBRUARY 1, 2004 10:00 p.m.

NAOMI CHANEY

			1 - For State Registrar	State of Ma		artment of H <i>rtificate of L</i>		d Mental Hygi	ene 20	04	02774
			Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of Death
	Physici		Bernard	Cas	well			January		2004	1:40 PM
	/Medic Examir		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of D		4c. County of	of Deeth	
	E Aum		Harbor Itos	pital		Balti	more	2		N/A	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birth (Month, Day,	Year)		ce (State or Foreign
	Director		215-22-0585	M 2□F	77 Yrs.	Months Days	riçuis ii		1926		yland
	p ,		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					100	d. Inside City Limits
	anyla	_	Maryland Anne Ar		Toc. City, Town of Ec	Glen B	urnia			100	1 ☐ Yes 2X☐ No
	Ne M	Director	10e. Street and Number					10	g. Citizen of W	hat Countr	
	With a					10f. Zip Code	1061	10	g. Citizen of w		y :
	e 23	Funerai	103 Governors Cou	12. Was Decedent E			1061	2 (Specify Ves or No-	14 Race	- American	Indian
	iter d	Š	1 Never Married 2 Married	Armed Forces? 1 XYes 2 No		If Yes, specify Cuba	n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		, White, et	
336	of, or	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:	WWII	1□Yes 2XNo	Specify:		Specify:	Wh:	ite
Ą	s within 72 hours after death with the Maryland jiene. I then naturel', or iteme 23a or 28e-f ehow I'le Medical Esaminer must be notified at	ted	15. Decedent's Educ			dent's Usual Occupa		1	6b. Kind of Bus	siness/Indu	stry
212	within 7 ene. than "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	life.	kind of work done of DO NOT use retired	during most of ()	working			
Maryland 21215-0036		Completed	12			igger			Shipya	ard	
2	be filed tal Hygid d other	Be (17. Father's Name (First, Middle, Last)					Name (First, Middle, M.		9)	
<u>Vla</u>		ဥ	William Caswell				Ceo	cilia Schud	er		
a	and and is m		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Maili	ng Address (Street a	and Number o	r Rural Route Number,	City or Town, S	State, Zip C	code)
	f Health item 27 other tra	1	Loretta M. Farb/da	ughter	3504	Westgate	Drive	Ellicott	City,	MD 21	1042
Ö	of of		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ R	emoval from State		matory or other plac			Oc. Location - 0		
Ē	tent:		`4 □ Donation 5 □ Other (Specify)			ematory,			Baltin		MD
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Tuneral Servix Linnse	mc Long	CX 2	Cremation	Societ	ty of Maryl	and, Ir	nc.	
			Dawly F.: McDor 23a. Part1. Enter the disease, or compli	hald				oad Baltim			28 Approximate
			shock, or heart failure. List only on	e cause on each line	э.			diac or respiratory arres	, , , , , , , , , , , , , , , , , , ,	1 1	nterval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	card	consequence of):	rhythu	mia			In	mediate
١,	Examiner				consequence of):			2000			veavs
	Şi.	- a	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):	citation of	UIS	case			7 cac
	uted ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ċ.	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):						
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical									
Φ	uffica ng ph as th	led									
Вох	death certific attending p	an/N	23b. was decedent pregnant	3c. If yes, outcome o		Ectopic pregnancy				of delivery	
	deat de att	sicle	in the past 12 months? 1 Yes 2 No	4☐Pregnant at t		Other (specify)			Mon	th D	ay Year
9. O	law requires that the de as been signed by the 2 should be detached	Physiclan/Me	9 ☐ Unknown								
Ś	es tha igned to be det	þ	Part II. Other significant conditions con		t not resulting in the u	nderlying cause give	en in Part I.				cause of death?
of Vital Record	been should	ted	Chronic Rev	iai iaii	04-6			1 Yes	2 No :	3 Probac	oly 4 □Unknown
e C	has b	Completed						24a. Was an autopsy	pr	rior to comp	y findings available detion of cause of
<u> </u>	Th ate pag	Con						perform 1 ☐ Yes 2	25-No 1	eath? Yes 2	□No
/ita	Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?					Death (Check only one)		
5	hys this al di	2	TE TOS ZECINO	ospital: 1 Inpatien			4 1401511	ng Home 5 🗆 Residen			
	fer fer	-i	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work	ς?	28d. Describe hov	v injury occurre	d	
Division	Attending P ir death. ector: After I by the funera	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injur	n. At home form at		Yes 2□No	28f. Location (Stre	et and Numba	e ne Dueni i	Pouto Mumbos
\leq	r i i i	Certification:	4 ☐ Homicide determined	building, etc.	ry - At home, farm, st (Specify)	eet, ractory, office		City or Town,	State)	i oi muiai i	noute tvurnoer,
_	To the Hospitel (within 24 hours all To the Funeral D completely filled in		29a. Certifier 1X Certifying Phys	sician: To the best of	f my knowledge, deat	h occurred at the tim	ne, date and n	lace, and due to the cau	use(s) and man	ner as stat	ed.
	• Ho: • Fur letely	Medical	(Check only 2 Medical Examinations)	ner: On the basis of and manner stat	examination and/or in	vestigation, in my or	oinion, death o	occurred at the time, dat	e and place, ar	nd due to the	ne cause(s)
	To the Ho within 24 to To the Fu completely	Me	29b. Signature and title of certifier			29c. License	number		d. Date signed		
•	/		1 Yamara 2	Kele	Do	100	5179	1]	anvari	1 30	, 2004
	5		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,	Print)	-				1
			Tamara L. Kile, D	3001	S. Hanov	er Street	Bal	Homore, M	D 218	7-72	
	Sta		31. Date filed (Month, Day, Year)	- 1	Signature	0					

ORIGINAL

			1 - For State Registrar		Maryland		artment rtificate			and M		eg. No. 🚄 U	04	02775
	Physici /Medic		1. Decedent's Name (First, Middle, Las JOSEPH IRVIN	coale J	R						January) 0 4′	3. Time of Death 8:40AMM
	Examir		4a. Facility Name (If not institution, give	street and numbe	er)		·		Location of	of Death		4c. County	of Death	
	•		4 Knollridge Ct	T -			Balt		'e If Under:	Od Ura			timo	
	Funeral Director		5. Social Security Number 6. Sr 215–16–9060		Age <i>(In yr</i> s. <i>Iasl</i> 30	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, June 1, 1	923	9. Birth	place (State or Foreign ntry) and
	D		Usual Residence of Decedent								.,		J	
	arylar ehow	ř	10a. State 10b. County		10c. City, T		cation							10d. Inside City Limits
	the M	ecto	Maryland Baltimore	·	Balti	more	10f. Zip	Codo				0g. Citizen of V	What Cour	1 ☐ Yes 2√√ No
	as or	Funeral Director	4 Knollridge Court					210			'	USA	vnat Cou	ntry r
	death me 2:	nera	11. Marital Status	12. Was Decede	nt Ever in U.S.	13.			spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Rac		can Indian,
9	after or Ita	/Ful	1 Never Married 2 Married	12. Was Decede Armed Force WX Yes 2 [If Yes, Give	jno WII		ryes,spec 1 ⊡ Yes 2		n, mexican Specify:	, Puerto	Hican, etc.)	Specify	k, White, Whi	
Ö	hours tural',	d by	XX Widowed 4 □ Divorced	Year or Date:				III C						
5	in 72 n "nal	plete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usua kind of wor DO NOT us	il Occupa k done d e retired)	ition luring most)	of worki	ng	16b. Kind of Bu	isiness/in	dustry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4d	or 5+)		residen					Envelope	e Comp	any
nd	be file tat Hy d othe	To Be Completed	17. Father's Name (First, Middle, Last)								(First, Middle, M	faiden Sumam	θ)	
Z	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Itama 23a or 28a-f ehow unatic event, the Medical Exercities must be notified at	٦	Joseph Irvin Coale Sr							e Pur				
Z S	and 2 st salth and n 27 is n		19a. Informant's Name/Relationship (7) Nancy C Baker								i Route Number, e, Maryla		State, Zip	o Code)
ē,	s 1 ar if Hea item other		20a. Method of Disposition		20b. Place	e of Dispo	sition (Nam	ne of	a)]	С	ate	20c. Location -	City or To	own, State
Ē	Pages nent of I ant: If its ary or o		1 ☐ Burial 2)(X Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from Sta)	re l		Cemete			1/29/	'04	Baltimo	ore, M	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Exercities man be notified at once.		21 Agnature of Funeral Softwige Licen	in Ken	akis	22	. Name and	d Addres			hell-Wied Road Balt			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caus	ed the death. [Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
	Pnysician /Medical	ñ	Immediate Cause (Final disease or condition resulting in death)	a. Chro	onic Obs	struc	tive	Puln	anary	Dis	ease		9	Onset and Death
	Examiner			Due to (or a	as a consequen	ce of):			- 3				,	
	e #	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequen	ce of):								
	cuted	Examiner	Cause (Disease or injury that initiated events	c										
8760,	rate be executed only sicien and the burial-transit		resulting in death) Last	Due to (or a	as a consequen	ce of):								
687	icate physics the t	dica		d										
Box (eath certifica attending pt for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			· ·					23d. Date	of delive	ery
B	e deat he attr	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal de at time of death		Ectopic pre Other (spe					Mor	ith	Day Year
P.O.	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions or			o in the ur	adorhijaa oo	ueo awo	n in Port I		23a Did tob	2000 HEQ CORE	ibuta ta H	ne cause of death?
Vital Records,	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	ted by	Tark and and an action of the control of the contro	THIS USING TO GOULD										ably 4 Unknown
Rec	he law e has b age 2 st	Completed									24a. Was ar autopsy perform 1 Yes 2	, ,	rior to co	psy findings available impletion of cause of
g		a	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes 2		Yes	2□ No
<u>></u>	Physic this ce al direc	To B	examiner? 1 □ Yes 2 X XIo	Hospital: 1 □ Inpa		Outpatien	t 3□ DO/	A Othe			ne XX Reside		r (Specifi	y)
o uc	ding Ph h. After th funeral		27. Manner of Death 1	28a. Date of In (Month, L	njury 28 Day Year)	b. Time of Injury		Bc. Injury Work	at ?	2	8d. Describe ho			
Division of	deati deati ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of I	njury - At home	farm stre	M factory		es 2□N		18f Location (Str	eet and Numbe	r or Rum	l Route Number,
2	al or At s after d it Direct od in by	Certification:	4 Homicide determined	building,	etc. (Specify)	, 10,171, 5110	sor, ractory,	OIIICO			City or Town	State)	or rigita	a riodio ridinibol,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	edical	29a. Certifier (Check only one) 2 Medical Exam	rsician: To the besiner: On the basis and manner	or examination	dge, death and/or inv	occurred a restigation,	it the time in my op	e, date and inion, deat	place, a	nd due to the ca	use(s) and mar te and place, a	nner as st	ated. othe cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1 66			_	License			29	d. Date signed		Day, Year)
•	V		John 11 C	geren					60Z			1/28/	7	
	V		30. Name and address of person who of	ompleted cause of	death (Item 23	a) (Type, I	SWSC	1 Lm	MD	2/2	7			
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	estel								
	Registr	ar	FFB 0 3 2004		Jan Jan	- Sheep								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** PANUARU 20:39 29 Arabella Chiles /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMOLE
If Under 1 Year If Under 24 Hrs. HEALTHCARE AGNES. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days 1 □ M 20XF 83 Yrs Pennsýlvania May 24. 1920 167–18–6637 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f ahow item 27 is marked other than "natural", or Itams 23s or 28s-f abov other traumatic event, the Medical Examiner must be notified at 1 Yes 20 No Maryland Baltimore **Baltimore** Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1203 Stamford Road 21207 United States Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental H Painter Maude Detweiler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara L. Blair - Daughter item 27 I 68 Carrillo Street Santa Rosa California 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. NBurial 2 ☐ Cremation 3 ☐ Removal from State 2/3/04 Meadowridge Mem. Pk. Elkridge, Maryland A □ Donation 5 □ Other (Specify) Cary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 21. Signature of Funeral Service Licenses Pala 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 015 100 **Physician** 010000 disease or condition resulting in death) /Medical Due to (or as a consequence)of): Examiner Sacrentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ormed? 2 No 1 Yes : After this certifice a funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 XNo Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. I Director: A 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by within 24 hours after To the Funeral Dire 4 | Homicide De Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier moure D

Registrar
DHMH 17 Rev 1/2001

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

Date filed (Month, Day, Year)

0

FEB 0 3 2004

aunders

32. Registrar's Signature

		1	For State Registrar	State of Marylan	d / Dep <i>Ce</i>	artmen rtificate	t of H e of L	lealth a Death	and M		giene g Reg. No.	2004	02	777
1	Arra B		Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Day	Year	3. Time	of Death
	Physiciai /Medica		Ruth	С.	Ca	llahar	1			Januar	cy 23	2004	7:2	0 P M
	Examine	100	4a. Facility Name (If not institution, give st	reet and number)		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Deat	h	
		18	Greater Baltimo			Tow						altimo		
	Funeral		5. Social Security Number 6. Sex	M 2 XF 7. Age (In yrs. I		Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th ly, Year)	Co	hplace (State untry)	
	Director		217-22-1427	82	Yrs.					Feb 5,	1921	. Ma	ryland	<u> </u>
	pur *	-	Usual Residence of Decedent 10a, State 10b, County	10c. City	y, Town or L	ocation							10d. Inside	City Limits
	sho	.											1 □ Y€	es 2 No
	Ne N	Director	Maryland Baltimon	re L	Tows	0 n 10f, Zip	Code				10a Citize	en of What Co	untov?	
	ours after death with the Marylar at', or itams 23a or 28a-f show Examiner rout be notified at	5				1		_						
	s 23	Funeral	8606 Drumwood Roa	3.0 2. Was Decedent Ever in U.	S 13		21286		igin? (Sp	ecify Yes or No		S.A.	nican Indian.	
)	ter de	Ä	11. Marital Status 1 □ Never Married 2 ★ Married	Armed Forces? 1 ☐ Yes 2 🕅 No	.3.	If Yes, spec	ofy Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		Black, Whit		
36	rs af	à	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 X No	Specify:			S	Specify: W	hite	
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or itams 23a or 28a-1 show ont, the Medical Examiner coust by notified at		15. Decedent's Educ	ation	16a. Dece	dent's Usua	al Occupa	ation			16b. Kind	d of Business		
215	n 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	b kind of wo DO NOT u	rk done d se retired	during mos d)	it of work	ring				
772	T than a	E	8	College (1-401 34)	Н	omemak	er				Ωw	n Home		
3 p	othe	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	er's Nam	e (First, Middle				
lan	d benta	0	John A.	Lvnch				Doi	ra	R.	Sal	isbury		
3//2//km Maryland	12 should be filed within n and Mental Hygiene. 7 is marked other than "raumatic event, the May		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mail	ing Address	(Street			al Route Numb	er, City or	Town, State, 2	Zip Code) 2	1043
(8 = 2 =	ı,	Joellen Callahan	Daughter	7727	7 01d	Wood	dstoc	k La	ne Ell	icott	City,	Marv1	and
() (ges 1 ar t of Hea if itam or othan		20a. Method of Disposition	20b P	lace of Disn	neition (Nar	ne of	1		Date		ation - City or		
Ę	Pages nent of t ant: If its ary or of		1 Donation 5 Other (Specify)	moval from State Ga	rrisor eterar	1 Fore	est leter	^v :	1-30	-2004	Owin	as Mil	ls Ma	ryland
Ħ	그 돈 뿐 글	1	21. Signature of Furnaral Service License		2	2. Name an	d Addres	ss of Facili		ck Tows				
ñ	Departiment in poor in		How Home		1	1050 Y	ork	Road		owson,			1204	
1			23a. Part1. Enter the disease, or complic	ations that caused the deat	h. Do not er	nter the mod	e of dyin	ig, such as	cardiac	or respiratory a	rrest,		Approxim Interval B	
	Physician :		shock, or heart failure. List only one		i L	0 /							Onset an	
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	NECC! T	taile	116						1045	
10	Examiner							the					1041	S
2	, 194	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	ex. 2 th carrie	aprel	rig						
1	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	Diabete	s Mel	litus							1091	5
Mi	exection and rial-tr	Exa	resulting in death) Last	Due to (or as a conseq										
760	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	cal	d.											
68	leath certifica attending ph													
Вох	h cer endir use	Physician/Med	23b. was decedent pregnant	lc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		□Ectopic pi	regnancy	,			23	3d. Date of de	- /	Wasa
a.	deat	100	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of d		Other (sp						Month	Day	Year
P.O.	that the de ed by the a detached	hys	9 🗆 Unknown	3CI OTKIOWII										
s,	igned the	by	Part II. Other significant conditions conf		ulting in the	underlying o	ause giv	en in Part I	l.			e contribute to		
ğ	w require been si	ed	Gastrointestinal &							142	Yes 2□	No 3⊟Pi	obably 4 [_]Unknown
တ္ထ	aw re	ple	Acute Renal Fa	ilure						24a. Was		24b. Were at	topsy finding	gs available
Division of Vital Records,	The tay ite has bage 2	Completed								perfo	ormed?	death?	2 No	
ital	ysician: The is certificate hadirector, page	0	25. Was case referred to medical					26. Place	e of Deat	h (Check only	one)			
>	ysici is ce direc	ToB	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1/2 Inpatient 2	ER/Outpatie	ent 3 DC	Oth Oth	ier: 4□Ni	ursing Ho	ome 5 Resi	idence 6	□Other (Spe	cify)	
0	ig Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time	of 2	28c. Injur	y at k?		28d. Describe	how injury	occurred	,	
.0	Attending r death. ector: After by the fune	atic	2 Accident investigation			М	1 🗀	Yes 2	No					
<u>×</u>	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, s fy)	treet, factor	y, office			28f. Location (City or To	Street and wn, State)	Number or R	ural Route N	umber,
(5)	rs aft	Č.												
(7)	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	cal		ician: To the best of my knows: On the basis of examina										e(s)
U	the h tin 24 the F	Medical	one)	and manner stated.										
	To To Con.		29b. Signature and title of certifier			29	A SIA	e number			1	signed (Mont		,
	/		19 mel Colo.	n MI)		16	1417	9/			1/2	5/04		
			THE RESERVE AND ADDRESS OF THE PARTY OF THE	and the state of t	NATIONAL CONTRACTS.	- W. W.								
	5		D A A A A A	1201 11/1	· colo	CH	1	/11.		1 MI	1 .	12011		
	Stat		BDMIL Cohen 31. Date filed (Month, Day, Year)	6701 N (6) 32. Registrar Signa	arte	16+	B	ulhn	10/1	110	1 21	1204		

	F COLE	1AI\	Terresident - State Registrar Amended Item#	State of Ma									nnu	02776)
			1. Decedent's Name (First, Middle, La		2/19/0	46961	lincate	3 OI L	Jeani		2. Date of Deat	g. No.	007	3. Time of Death	_)
	Physici		- ANTONIO L.		JR. A	ntani	o Land	nt Co	oleman		Month January	Day 27.	Year 2004	17:34 M	
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, 7	Town, or	Location o	of Death			nty of Death	17.031	_
			900 block of Same	rset Stree	t			timo				N,	/A		
	Funeral		5. Social Security Number 6. S	DM 2DE	(In yrs. last b	oirthday) Yrs.	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Coun		7
	Director		Usual Residence of Decedent	X	24	113.					MAR. 3	,197	9 MAR	YLAND	_
	/land		10a, State 10b. County		10c. City, To	wn or Lo	cation						1	0d. Inside City Limits	_
	ith the Marylan or 28a-f ehow or notified at	tor	MD. N/A		Е	BALT	IMOR	E						1 X Yes 2 ☐ No	
	or 28	Director	10e. Street and Number				10f. Zip				10	og. Citizen o	f What Coun	ntry?	
	23e vi		841 N. MONTE	ORD AVEN	UE		21	205				U.	S.A.		
	tams tams	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decede f Yes, speci	ent of His	spanic Orig n, Mexican	gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)		ace - Americ lack, White,		
36	s afte	by Fi	X ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	0		1 ☐ Yes 2	No ∑	Specify:			Spec	eily BLAC	'K	
8	within 72 hours after death with the Maryland ene. than 'neturel', or Itams 23e or 28e-f ehow the Mudical Examinar musi be notified at		15. Decedent's Ed		16	a. Deced	dent's Usual	I Occupa	ition				Business/Ind		_
215	n 77	Completed	(Specify only highest gra			(Give	kind of worl DO NOT us	k done d	uring most	t of workir	ng			,	
2	giene giene gr the	mo.	10TH	College (1º401 54	' t	JNE	1PLOY	ED				N/A			
p	be filed ital Hygid of other event, I	Be (17. Father's Name (First, Middle, Last)								(First, Middle, M		ame)		
yla	2 should be and Mental is marked (saumatic ev	2	ANTONIO L. COL								V. DA	·			_
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla I Heath and Mental Hygiene Item 27 is marked other than "natural", or Itams 23e or 28e-f ehov other traumatic event, Ine Medical Examinar must be notified at		19a. Informant's Name/Relationship (1						Route Number,	City or Tow	n, State, Zip	Code)	
e,	1 and Health em 27 ther t		MICHELE PAGE (20a. Method of Disposition	SISTER)	20b. Place	/ () () of Dispo	e. 3	2nd	Str				212 1 - City or To		_
o D	Pages nent of I ant: If its ary or o		X□ Burial 2 □ Cremation 3 □		cemet	ery, crer	natory or oth	her place	´	7 20			,		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		4 □ Donation 5 □ Other (Specify 21 Signature of Funeral Service Licer		111 . 2		Name and						ORE,M	D.	
ä	permit. Departr Importe eny inju		19 esmadenis	The Acre	401		CALVI 417	N B	. SC	RUGO	S FUNE	RAL	HOME	1213	
9	O O W S	1 3	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that crused to	th death. Do								10.	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	One cause on acrimie	Noch	The	11/50	مد	l to	He	ad		- 1	Onset and Death	
	/Medical		resulting in death)	a. Due to (or as a	consequence	e of):	V								
M	Examiner		Saquentially list conditions.	8											
	D #	Examiner	Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	a of):									
	be executed sician and burial-transit	хаш	that initiated events resulting in death) Last	c Due to (or as a	consequence	e of)-									
8760	ate be executed hysician and the burial-transit				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,-									
687	ate hy: the	edical		_ d											_
Вох	ndin use	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			· ·					23d. D	ate of delive	ry	
	death e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti			Ectopic pre Other <i>(spe</i>					N	fonth	Day Year	
о <u>.</u>	at the de by the a stached	Physician/Me	9 🗆 Unknown	9□ Unknown								1 -			
Ś	The law requires that the tee been signed by the bage 2 should be detache	by F	Part II. Other significant conditions of	ontributing to death but	not resulting	in the ur	nderlying ca	use give	n in Part I.					e cause of death?	
ord	een s	ted									1 L Yes	2 No	3 Proba	ably 4 Unknown	_
Sec.	e 2 sl	Completed									24a. Was an autopsy		prior to con	sy findings available reletion of cause of	
											Yes 2	Bd? □ No	death? Yes	2□ No	
<u> </u>	or Attending Physician: ifter death. Director: After this certific in by the funeral director.	o Be	25. Was case referred to medical examiner?	Hospital:				Other			(Check only one				_
Division of	Phys ar this aral dir		15√ Yes 2 No 27. Manner of Death	1 Inpatien 28 Date of Injury (Month, Jay		Time of		Bc. Injury Work	4 🗆 Nui		e 5 ☐ Resider			SCENE	-
0	nding l ath. r: After e funer	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	11 5 - 10	Year)	Injury	М	Work′ 1 ☐ Y		No S	while	A 81	-st-		
N N	or Attendated distribution of Attendated Director: in by the	tifica	3 Suicide 6 Could not be determined		y - At home, f	arm, str	et, factory,	office	-	2	8f. Location (Stre City or Town,	et and Num	ber or Rural	Route Number,	
<u></u>		Cer		(/	NA	UT	(D)	_		9	30 31.	201	erset	र्ग.	
	호 수 필 우	edicai	(Check only 2X Medical Exan	ysician: To the best of niner: On the basis of e	examination a	ge, death ind/or inv	occurred a	t the time	e, date and inion, deat	d place, a	nd due to the car d at the time, da	use(s) and m	nanner as sta	ated. the cause(s)	
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner state	ed.			License					ed (Month, E		_
•	5 2 2 S		A A	1 //2	-6		250.		O.C.M	1.E.	1	_	28, 2		
	h		30 Name and addréss of berson who	completed cause of de-	ath (Item 23a)	Tune	Print)								
	2		30. Name and address of berson who	= MiD	(111	Penn :	Stre	et, E	Balti	more, Ma	arylan	d 2120	01	
	Sta		31. Date filed (Month, Day Year)	32. Régistrar	's Signature	Ry	agard of		,						_
	Registr	217	7 20 0 0 20	V 1 /3		Chord .	220713	to de	/						

			For 1 State Registrar	State of	Marylar	•	artment of F				giene Reg. No. 2	004	02779
		44	Decedent's Name (First, Middle,	Last)				-		2. Date of Dea	ith		3. Time of Death
	Physici /Medi		Herman J. Di	Marino						Month January	Day 29	2004	6:10P M
	Examir		4a. Fecility Name (If not institution, g		ber)		4b. City, Town, o	r Location of	of Death		4c. Co	unty of Death	, 0,20
			3644 Elmley	Avenue			Baltimo	re					
	Funeral			Sex 7 1⊠M 2□F	. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	r, Year)	9. Birthp	lace (State or Foreign
<i>6</i> 2	Director		220-03-3380	IZIM ZUF	88	3 Yrs.				Oct. 25	5, 19	15 Mary	land
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					1	Od. Inside City Limits
	Aaryl F sho	ō	Maryland			Baltimo							1√2¥es 2 No
	the 288-	Director	10e, Street and Number			Dartimo	10f. Zip Code				10a. Citizen	of What Cour	ntry?
	3a or	٥	3644 Elmley A	Venue			212	1 2					•
	ours after death with the Marylan rst', or items 23a or 28a-f show Examiner must be notified at	Funeral	11. Marital Status	12. Was Deced	lent Ever in U	.S. 13.	Was Decedent of H		gin? (Spe	cify Yes or No-		J.S.A. Race - Amend	
9	after or the		1 ☐ Never Married 2 ☐ Married	Armed Ford	No No					Rican, etc.)		Black, White,	etc.
03	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examinat must be molitled at	l by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	les:		TLI Yes 21 No	Specify:			Sp	ecify:	White
5-0	within 72 hours iene. 'than "natursi", I're Medical Ex	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup	during mos	t of workir	ng	16b. Kind	of Business/Ind	dustry
21	within iene. than	du	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retired	d)					
2			6 17. Father's Name (First, Middle, La	at)		<u> </u>	'ireman	10 Moths	rda Nama	(First, Middle,		ailroad	
anc	be dala	Be									Maluell Sul	mame)	
ž	should ind Men marke umatic	²	Antonio DiMar 19a. Informant's Name/Relationship			19h Mailir	ng Address (Street			lancini	r City or To	own State Zin	Cade
Maryland 21215-0036	d 2 sho th and t7 is mu traum	8	Robert DiMarino				sswood Co						
	is 1 and 2 should of Health and Mer ttem 27 is marke other traumatic	11	20a. Method of Disposition	(iiopiioii)	20b. f	Place of Dispo	sition (Name of	1		ate		ion - City or To	
JO L	0 0		1 ☑ Burial 2 ☐ Cremation 3 1 ☑ Donation 5 ☐ Other (Spe		tate	_{сететегу, сгег} laney `	matory`or other plac V a 11 e v	CB)	2-2	-2004	Timon	ium, Ma	aryl and
Baltimore,		1	21. Signature of Flineral Service Lin		1 1	2	Name and Addre	ss of Facilit	v				
B	permit. Departr Imports any inju		(Xenad	19/1	1	/ Ni	tzke Fune	eral H	lome	of Cato	nsvil	le, In	c. and 21228
	3 .		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that ca	used the deat							1141	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	ly one cause on ea) // h	1.1	A.	//1	1				Onset and Death
	/Medical		resulting in death)	Due to (o	r as a consec	juence of).	n Cluy	/ VM			- A		
	Examiner		Requestially list conditions	1 V	Velu-	1	heart	dise	an	A .	1.1.	_	50 year
7.7	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (a con ec	quence of):							0
	ecute and -trans	Examin	that initiated events resulting in death) Last	C. Due to (e	r as a conseq						<u> </u>		
8760,	ate be executed only sicial and the burial-transit	Ē	,		r as a conseq	(dence or):							
87	death certificate be executed e attending physician and nd for use as the burial-transit	dical		d									
9 X	eath certific attending pl for use as t	/Me	IF FEMALE:	23c. If yes, outc	ome of pregna	ancv					224	. Date of delive	
Вох	atter for u	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1☐Live bir	th 2□Feta nt at time of d	ul death 3 [Ectopic pregnancy Other <i>(specify)</i>	,			230.		Day Year
0	the d y the iched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov			2 0 11 01 (0) 00 11 //						
D	law requires that the de as been signed by the 2 2 should be detached i		Part II. Other significant condition	contributing to dea	ith but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to th	e cause of death?
Vital Records,	quires n sign	d by	_							1 □ Y	es 252N	lo_ 3 ☐ Prob	ably 4 Unknown
00	law requir as been si 2 should I	Completed								24a. Was a		4b. Were autor	psy findings available
R	0 - 0	mo m								autop: perfor		death?	npletion of cause of
ta	ian: Th rtificate stor, pag	0	25. Was case referred to medical					26. Place	of Death	(Check only of			20110
f V	Physician: this certific ral director,	To B	examiner? 1 🗆 Yes 2 🗖 No	Hospital: 1 ☐ In	patient 2	ER/Outpatier	nt 32 DOA Oth	er: 4 □ Nu	rsing Hon	ne 5 Resid	ence 6 🗆	Other (Specify	<i>(</i>)
n of			27. Man o Death 1 ∠Natural 5 ☐ Pending	28a. Date of (Month	Injury Day Year)	28b. Time of Injury	28c. Injun Wor	y at k?	2	8d. Describe h	ow injury oc	ccurred	
Sio	at at at	atic	2 Accident investigation					Yes 2□I	No				
Division	or Attendated after deatl	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina	ad 286. Place C	of Injury - At h g, etc. <i>(Specii</i>		eet, factory, office		2	8f. Location (S City or Town		umber or Rura.	I Route Number,
Ω	oital o			<u> </u>									
£	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier 1 Certifying (Check only 2 Medicel Ex	Physician: To the beeniner: On the bas	sis of examina	owledge, deatl ition and/or in	n occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, a th occurre	nd due to the c d at the time, d	ause(s) and late and pla	d manner as st ice, and due to	ated. the cause(s)
`	ithin 2 o the	Mec	29b. Signature and title of certifier	and manne	stateu.		29c. Licens	e number	·	2	9d. Date si	gned (Month, I	Dav. Year)
	Vor Con			100	h		0	C (10		9	7 1	1.
	'n		30. Name and address of person with	io completed cause	of death (lter	n 23a) (Type	Print)	100	> T		-	6 0	-(
	9		10754 =	12 A 1	Ct.	320	f r	Hea		(1)	12	5-1	7 90
	Sta	ite	31. Date filed (Month, Day, Year)	32 Re	gistrár's Signa	ature		/		t	V V	t	
	Regist	ar	FFR 0.3.2	004	was a d	e L	1000						

State of

Maryland / Department of Health and Mo	ental Hygiene	00	7
Certificate of Death	Pen No	UL	1

			1 - State Registrar				Ce	ertificate of	Death		Reg. No	o U (1 45	02100
	Physicia /Medic		1, Decedent's Name (First, JAMES		DUNCAN					2. Date of Dea Month Januar	Da	ay \	rear	3. Time of Death
	Examin		4a. Facility Name (If not inst	itution, give s	treet and numbe	er)		4b. City, Town, o	r Location of Death	1	40	c. County of	Death	
			Sinai Hospit	al				Baltim	ore					
*	Funeral Director		5. Social Security Number 491 38 6040	6. Sex	M 2□ F	Age (In yrs.	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De 6 / 19 /	y, Year	7)	9. Birthp Coun	lece (State or Foreigr stry) SOURI
7	0		Usual Residence of Decede			_							1.	
	Marylan I show	tor	MD. 10b. Co	ounty		10c. Cit	ly, Town or I B	Location ALTIMORE	E				1	0d. Inside City Limits 1 XYes 2 □ No
1	289	Director	10e. Street and Number					10f. Zip Code			10g. C	itizen of Wh	at Coun	itry?
1	3a or	i Di	3603 SP	RINGD	ALE AV	Đ		21	216			USA		
36	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. 4 Hy	by Funerai	11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 ※ Divided 1.	Married	2. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	s? No	.S. 13	Was Decedent of H If Yes, specify Cub.	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		14. Race	Americ White,	
21215-0036	"natura			edent's Educ	ation		16a. Dec	edent's Usual Occup re kind of work done DO NOT use retired	pation during most of work	king	16b. l	Kind of Busi	n <i>e</i> ss/Ind	dustry
2121	yiene.	Completed	Elementary/Secondary (0 12	-12)	College (1-40	or 5+)			RKER		(CONST	RUC	CTION
Maryland		To Be C	17. Father's Name (First, Mi ROBER		DUNCA	N			18. Mother's Nam	ne (First, Middle, IILDRED				}
ا کے	should and Meni marke umatic		19a. Informant's Name/Rela	itionship (Ty)	oe, Print)		19b. Ma	iling Address (Street	and Number or Ru	ral Route Numbe	er, City	or Town, Si	tate, Zip	Code)
Ž	and 2 saith a n 27 is		LINDA MOR	SE	SISTE	R	360	3 SPRING	GDALE AV	E. BAL	TO.	. MD.	21	216
more	Pages 1 ar nent of Hea int: If item iry or othe		20a. Method of Disposition 1	ition 3 □R	emoval from Sta			position (Name of ematory or other place) CREMATO		Date / 04		_ocation - C		um, Stete
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Se		" Of	Ste	D	22. Name and Addre		BALTO.	MI	D. 21	217	,
200	nysician /Medical Examiner		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	se, or complication of the control o	e cause on each	i line.	Sive (nter the mode of dyin	1 10 - 1	or respiratory are		- Dis	£ 4.4	Approximate Interval Between Onset and Death

attending physician a

been signed by the should be detached

page

After

death.

within 24 hours after death.
Tothe Funeral Director: A completely filled in by the fu

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

Completed by

Be

일

Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b Due to (or as a consequence of): Due to (or as a consequence of):

IF FEMALE 23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No

9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 2 Fetal death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Dav

23e. Did tobacco use contribute to the cause of death?

2 🗆 No

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 Yes 2 No

1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 27es 2 No

26. Place of Death (Check only one)

111 Penn Street, Baltimore, Maryland 21201

3 Probably

25. Was case referred to medical examiner? Other: 1 🗌 Inpatient 2 P/Outpatient 1X Yes 2 No 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Injury 1 **Tiva**tural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME January 31 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) Mike 32. Redistrar's Signature

			1 - For State Registrar		aryland / Depa	artment of I	Health and I	Mental Hygier		0278!
	Physic	ian	Decedent's Name (First, Middle, Last Citt to soon a					2. Date of Death Month	28, 2004	3. Time of Death
	/Medi Examir		Giuseppa 4a. Facility Name (If not institution, give	Disalvo		4h City Town	or Location of Death		28, 2004 4c. County of Death	8:30 P M
	CXamii	ier	407 Dale Avenue	stroot Ero namoor,			timore	·		imore
	Funeral Director	Γ	5. Social Security Number 6. Se	х] м 2 Д (F	e (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	_	(Month, Day, Yea		plece (State or Foreign
	pus 🖈		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	eation				
	he Maryla 8a-f shor	Director	Maryland N/A		roc. City, Town of Lo	Baltimor	ie			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or 2	I Dir	10e. Street and Number 528 N. Linwood	Avenue		10f. Zip Code	2120		Citizen of What Cour U.S.A.	ntry?
	oms 2	inera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Vas Decedent of H	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No-	14. Race - Americ	can Indian,
9000	n 72 hours after death with the Maryland "natural", or itams 23a or 28a-f show edical Examinar must be notified at	d by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 XI If Yes, Give Year or Dates:	No.	Yes 2X No		o riicaii, etc.)	Black, White,	
215-(C *_ A	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of work	king 16b.	Kind of Business/In	dustry
121			5th Grade			memaker			Own Home	
Maryland 21215-0036	be de la be	To Be	17. Father's Name (First, Middle, Last) Vincenzo Rome				Antonir		ibetta	
Mai	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Ty Mr. Giuseppe Giam					ral Route Number, City t Scaaast		Code) 20723
Baltimore,	of He of Heron		20a. Method of Disposition		20b. Place of Dispo.	sition (Name of		Date 20c.	Location - City or To	wn, State
ij	7 1 6 P		1 Burial 2 Cremation 3 F '4 Donation 5 Other (Specify)		t Parkwood	Mausoleu	1/3	1/2004 Pa		
Bal	permit. Departm importa any inju		21. Signature of uneral Service Licens	na		705 Bela	ur Rd., 1	himunek Fur Baltimore,		2.5
	Physician /Medical Examiner		23a Fart1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	PNE	the death. Do not entered to the consequence of):		ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
,	sate be executed shysician and the burial-transit	Examiner	Sequentially list conditions, if any, Jacob to inmodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (br as i	a consequence of):					
8760,	icate be physicia s the bur	Ical		1.						
P.O. Box 6	ath certif	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions cor	ARGE	- 1/	derlying cause give	en in Part I.	_	use contribute to th	e cause of death?
Vital Records,	Physician: The law requ this certificate has been ral director, page 2 shoul	Completed						24a. Was an autopsy performed?	prior to con death?	psy findings available appletion of cause of
Vita	ician: Th	Be	25. Was case referred to medical examiner?	ospital:				h (Check only one)		aughtants
Division of	r Attending Physer death. rector: After this by the funeral dis	tlon; To	1 Yes No 27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatier 28a. Date of Injun (Month, Day	y 28b. Time of	28c. Injury Work	4 ⊔ Nursing Ho	ome 5 Residence 28d. Describe how inju	6 X ther (Specify occurred	lesidence
Divisi		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry · At home, farm, stre . (Specify)	_		28f. Location (Street a City or Town, Stat	nd Number or Rural e)	Route Number,
	To the Hospital or within 24 hours afte to the Funeral Dirk completely filled in Ir	Medical (29a. Certifier (Check only one) Check only one) Certifying Physical Exemination (Check only one)	ician: To the best of er: On the basis of and manner stat	f my knowledge, death examination and/or invited.	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the cause(s red at the time, date an	s) and manner as sta d place, and due to	ated. the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier	0	A	29c. License	194		ate signed (Month, E	/
	\Z		1 and 1 150	exera	MO		37708	3 1	· 30·	04
	γ\			RA MT	3243	El/10	TO 50	- BALS	TO, M.D.	21224
	Sta Registra	76	31. Date filed (Month Day Yaar) 2004	32 Registra	r's Signature	a				

		1	For State C	of Maryland		artment of Hertificate of I	lealth and Me Death	ental Hygien Reg. N		02782
	D		1. Decedent's Name (First, Middle, Last)	0.15.	. 1	2			ay Year	3. Time of Death
	Physicia /Medic	al -	ELLSWORTH ARNOLS		N,	JR.	- Landing of Dooth	IANUARY 2	7, 2004 c. County of Deal	
	Examin	-1	4a. Facility Name (If not institution, give street and no		CADI	4b. City, Town, of	Location of Death	<i>t</i> '	N/A	
	Eupoval		SALTIMULE REHABILITATION 5. Social Security Number 6. Sex	7. Age (In yrs. Yası	t birthday	If Under 1 Year		8. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign
	Funeral Director		486-48-5079 1 ¹ √2 M 2□ F	59	Yrs.	Months Days	Hours Min.	Jan. 13 19	45 Mi	ssouri
	pur &	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or L	ocation				10d. Inside City Limits
	Marylis f sho	ō	Md. n/a	Ra 1	timo	ro				1 ∑Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number	Dat	CIMO	10f. Zip Code		10g. (citizen of What Co	puntry?
	death with the Maryland ms 23a or 28a-f show r must be notified at	ai D	3806 Dorchester Road			212			U.S.A.	
	tems	Funeral Director	Armed F		13	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
0000	be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "natural; or flems 23a or 28a-f show other than "natural; or flems 23a or 28a-f show awant. The Medical Evaluate must be notified at	by F	1 Never Married 2 Married 1 M Yes If Yes, G 3 Widowed 4 Divorced Year or	2□No live Dates:Vietna	m	1 ☐ Yes 2 汉 No	Specify:		Specify: 1	white
5	a filed within 72 hours it Hygiene. other than *natural', vent, the Medical Eral		15. Decedent's Education (Specify only highest grade completed		16a. Dec	edent's Usual Occup	ation during most of working	16b.	Kind of Business	/Industry
7	thin 7	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)	life.	DO NOT use retired	i)		7 -	hi an
7	lled w tygier her th		12 +	3	Sal	esman	18. Mother's Name	(First, Middle, Maide	Construct	CTOIL
yland	ould be fi Mental It Marked of	o Be	Ellsworth Arnold	Dean Sr				zabeth Jol		
≘.	C D F F	2	19a. Informant's Name/Relationship (Type, Print)		19b. Mai	-	and Number or Rura	Route Number, City	or Town, State,	Zip Code)
Mar	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Jonathan B. Dean			•	e, Pasade			
ore,	of He of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	n State 20b. Plac	e of Disp netery, cr	position (Name of ematory or other place	ce)		Location - City or DWnsvill	
Baltimor	t. Pag tment rtant: njury o		4 □Donation 5 □Other (Specify)	Mary			Cem.01/30			
g	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 2005s.		21. Signature of Funeral Service Licensee Kev	in E. Eck	er	McCu	ss of Facility 111y-Polyn: Mountain	iak Funera Road Pag	al Home :	P.A. Md. 21122
Ы			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death.	Do not e	nter the mode of dyir	ng, such as cardiac o	r respiratory arrest,	sauciia,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ASTATIC	G	ASTRINO	MA			Onset and Death
	/Medical Examiner		resulting in death)	o (or as a conseque	nce of):					
	Examine	-	Sequentially list conditions, b. Due to	o (or as a conseque	nce of):					
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events c.	(
o,	execu en and rial-tra			o (or as a conseque	nce of):					
8760	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d							
Õ	entific ding p	0	IF FEMALE: 23c If yes, o	utcome of pregnance	v				23d. Date of de	livery
Вох	attendation	Completed by Physician/M	in the past 12 pronths?	birth 2 Fetal degrant at time of dea	eath 3	☐Ectopic pregnance	у		Month	Day Year
o.	t the d by the ached	hysi	1 ☐ Yes 2 🝱 No 9 ☐ Unknown	nown						
o,	w requires that been signed to should be dete	by P	Part II. Other significant conditions contributing to	death but not resulti		underlying cause giv	ven in Part I.			o the cause of death?
Records,	equire sen si nould l	ted	ZOLLINGER ELLISON	5400100	ME	HYPER	160>100	1 🗆 Yes		robably 4 Dunknown
ec.	ne lawa has bi ge 2 sh	mple	CORONARY ARTERY DIS	EASE, F			WE	24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
	iclan: Th certificate rector, pag	e Co	25. Was case referred to medical	PULMINA	RY 2	DISEASE	26. Place of Death	1 Yes 2 X	No 1 ☐ Yes	2 No
Vita	/sicial s certi directo	To Be	examiner? Hospital:	☐Inpatient 2☐EF	R/Outpat	ent 3 DOA Ott	ner: 4 Nursing Hor	1	6 ☐Other (Spe	ecify)
Division of	ig Phy ter thi	n: T	27. Manner of Death 28a. Dat	e of Injury 2 onth, Day Year)	8b. Time		ry at rk?	28d. Describe how in	jury occurred	
Sio	lendir eath. or: Af the fu	catic	2 Accident investigation]Yes 2□No	28f. Location (Street	and Number of P	tum I Routo Alumbar
Ξ	or Att	Certification;	determined 200. Fld	ce of Injury - At hom Iding, etc. (Specify)	ie, iarm,	street, factory, office		City or Town, St		urar noute Number,
<u> </u>	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To t	he best of my knowl	ledge, de	ath occurred at the ti	me, date and place, a	and due to the cause	(s) and manner a	s stated.
1	he Ho in 24 l he Fu pletely	Medical	(Check only 2 Medical Examiner: On the one)	basis of examination	n and/or					
	To t with To t	Σ	29b. Signature and title of certifier	On.	n	29c. Licens	IK A E	29d. l	Date signed (Mon	in, Day, rear)
,	4		muon Cill	MA THOSE OF	321 1	e Print)	1408	JAN	URNY Z	1,0004
	1)		30. Name and address of person who completed ca	LOCH RA	VEN	BOULEVA!	RD BALT	IMORE,	ND 212	18
	Sta	ate	31. Date filed (Month, Day, Year) 32	Registrar's Signatu	ire				V.	
	Regist	rar	FFD 0 8 2004 A	Rosen . As	45	Cornell 1				

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland / D	epartment of Health and N Certificate of Death	•	ne 2004 0278.
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) SHARON 4a. Fecility Name (If not institution, give s HARBOR ROSPIT	25 46	DAVIS 4b. City, Town, or Location of Death BALTIMURG	JANUARY	Dey Yeer 3. Time of Death 12.4c PM 4c. County of Death n/a
Ì	Funeral Director		5. Social Security Number 212-44-7033 6. Sex 1 Usuel Residence of Decedent		nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 29 19	946 Maryland
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ent, the Medical Examinar must be notified at	ector	Md . 10b. County n/a	10c. City, Town Balt	or Location imore 10f. Zip Code	100	10d. Inside City Limits 1 √√ Yes 2 □ No Citizen of What Country?
	23a or	al Di	1701 William Stre	eet	21230		U.S.A.
336	should be fited within 72 hours after death with the Marylan nd Mental Hygiene. marked other then "natural", or items 23e or 28e-1 show marked other then "natural", or items 25e or 20e-1 show marked other than "standing" and "natural be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Y Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 hou ane. then natura	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	ing	b. Kind of Business/Industry
/land 2		To Be Co	12 17. Father's Name (First, Middle, Last) William H.	Davis Sr		e (First, Middle, Maid	· ·
Mar.	d 2 sho th and 7 is mu traum		19a. Informant's Name/Relationship (Type Jeanette O' Neal		Mailing Address <i>(Street and Number or Run</i> 384 Hilda Ave. Pasad		
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a gonce.		20a. Method of Disposition	20b. Place of I			c. Location - City or Town, State
Baltimore,	I. Page itment rtant: If		1 ▼ Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	Glen H	laven Mem. Pk. 02/03		len Burnie, Md.
Ra	Departiment of the particular		21. Signature of Fuheral Service License	Kevin E. Ecker	22. Name and Address of Eacility McCully-Polynia 130 E. Fort ave	ak Funeral	Home P.A.
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,	
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	(1) :		
8760,	ate be executed hysician and the burial-transit	cal	that initiated events resulting in death) Last	Due to (or as a consequence of	·		
O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2V☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Hecords,		Completed				24a. Was an autopsy performed	
ō	ling Phys I. After this uneral di	atlon; To Be	25. Was case referred to medical examiner? 1 Yes ANO H 27. Manner Death Natural 5 Pending 2 Accident investigation	ospital 2 ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Till Inj	oatient 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 28d. Describe how in	e 6 ⊡Other (Specify) njury occurred
Division	ital or Attendi irs after death. ral Director: A led in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At home, fair building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital or, within 24 hours after To the Funeral Direction Completely filled in the formula of the form	edical	29a. Certifier Certifying Physical (Check only one)	ician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signatur, and title of certifier		29c. License number		Date signed (Month, Day, Year)
	0		30. Name and address of person who con	0	ype, Print)) JAI	NUARY 30 2004
	Sta	to.	ARPITA .HINGORI 31. Date filed (Month, Day, Year)	32. Registrar's Signature	HANOVER STREI	=T BA	LTIMORE
	Registr		FER 0 3 2004	Acada to do	alle		

		1	For State Registrar	State of Maryland	d / Department of Health and M Certificate of Death	lental Hygie	- (U U U	02784
			1. Decedent's Name (First, Middle, Las	t)		2. Date of Death Month	Day Year	3. Time of Death
М	Physicia /Medic		MARSHALL	DUBIA	<i>J</i>	JANUARY	29th 2004	8:00 P M
	Examin	_	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	0
			LEVINDALE		ast hirthday) If Under 1 Year I If Under 24 Hrs.	9 Pata of Birth	W//	ece (State or Foreign
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	ear) / Coun	
1 San	Director	1	Usual Residence of Decedent	0 -		001.10,	1101011	
	yland		10a. State 10b. County (Lt.)	NKNOWN) 10c. City	y, Town or Location	1	10	0d. Inside City Limits 1 → Yes 2 □ No
	Mar Hitie	Ş	NEW YORK		BROOKLYN	J		
	or 28	Oire	10e. Street and Number	10	10f. Zip Code	10g	. Citizen of What Coun	try?
	ath w	<u>ra</u>	201 EASTE			S acity Yes or No-	14. Race - Americ	an Indian.
	lterra Item	Funerai Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 2 Yes 2 □ No		Rican, etc.)	Black, White,	etc.
936	urs at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 Ñ No Specify:		Specify: BL	ACK
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or items 23a or 28e-f ehow odher than "natural", or items 23a or 28e-f ehow event, the Maulcal Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16	b. Kind of Business/Inc	dustry
21	within ene. than "	E I	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	ER	LINION	1199
	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	PHD	18. Mother's Nam	e (First, Middle, Ma	iden Sumame)(UNA	(NOWN)
Maryland	ould be t Mental I harked of	To Be	ABRAHAM	\triangleright	UBIN			-
7	d 2 should th and Mer 7 Is marke treumatic	۳	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	al Route Number, C	City or Town, State, Zip	Code)
	alth a 27 ls		DR. JOHNATHAN DU	IBIN (SON)	515 STABELERS CH	UKCH RD	, PARKTON,	MD. 21120
J.C	ges 1 and t of Healt if item 2 or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Disposition (Name of temetery, crematory or other place)		. Location - City or To	
<u>E</u>			*4 □Donation 5 □ Other (Specific	y) 19E	ETRO CREMATORY 01-3	30-04 C	DALTIMOR	E, MARYLAND
Baltimore,	permit. Pag Dep rtment Importent: any injury o		21. Signature of Funeral Service Licer	A/1, 700 mil	22. Name and Address of Facility 3. SEPH H.	ROWN JI	R. FUNERA	L HOME
	20240		23a Part Foter the disease or com	plications that caused the deat	h. Do not enter the mode of dying, such as cardiac		BALTO, M.	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				Interval Between Onset and Death
ш	Physician /Medical		disease or condition resulting in death)	a. CORON ARLI				3 YEADS
	Examiner			b				
	7 **	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cone ag	quenca of):		4	
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	urance of):			
760,	ite be executed lysician and ne burial-transit	cai E		Day (0 (0) 23 2 3011300	por 100 317.		14	
687	a × a			_ d				
Box (The law requires that the death certificat the has been signed by the attending phypage 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta			23d. Date of delive	•
	es that the death igned by the atte be detached for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of o			Month	Day Year
P.0	at the by th	hys	9 Unknown			330. Did taha	cco use contribute to the	ne cause of death?
	igned be de				sulting in the underlying cause given in Part I.		2 □ No 3 □ Prot	
Records,	w requir been si should	Completed	DEMENTIA.			24a. Was an	- 31	psy findings available
ec	e law has b	mpie				autopsy performe	prior to co death?	mpletion of cause of
<u>=</u>	r: Th icate r. pag		25. Was case referred to medical		ne. Place of Pag	1 ☐ Yes 2 € th Check onlone	⊋No 1 ☐ Yes	2 No
Vital	Physician: this certificant	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	Other		ce 6 □Other (Specif	(y)
of		n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at Work?	28d. Describe how		
Ö	Attending r death. sctor: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	M 1 □ Yes 2 □ No			
Division	r Atte	tiffe	3 Suicide 6 Could not be determined		nome, farm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
0	urs aff	Cel			and also death assured at the time data and place	and due to the en-	(a) and manner as a	totad
	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certification;	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the basis of examination manner stated.	owledge, death occurred at the time, date and place ation and/or investigation, in my opinion, death occu	rred at the time, dat	e and place, and due to	o the cause(s)
	o the	Me	29b. Signa ∟re and title of certifier		29c. License number	290	d. Date signed (Month,	Day, Year)
	F > F 0		Ronger M.	Querily.	m.0 054739	JA	ANUARY 30	th 2004
	1		30. Name and address of person who	completed cause of deam (Ite	m 23a) (Type, Print)			-
			2434 W. Belo	- 05-01	nue, Balhmore 1	rarylan	Id 2/2/5	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature			
	Regist	rar	FFR 0 3 2004	1 4 1 2	STOBAGE!			

DHMH 17 Rev 1/2001

ORIGINAL

			Please Type or Prin				
		4	For State of Ma	•	nent of Health and M		2004 02/00
_			Registrar	Certili	icate of Death	Reg. N 2. Date of Death	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last)	_	NI LARNE	Month D	Day Year 17.20 AM
	/Medic	al -	HATTIE U		. City, Town, or Location of Death	Danuary	Ic. County of Deeth
	Examine	er	4a. Fecility Name (If not institution, give street and number)	100	2011-2000		A110
			0. 10130011300		Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthplece (State or Foreign
	Funeral Director		221-18-8166 10M 2DE	82 Yrs. Mc	onths Days Hours Min.	DEC, 05.1	921 VIRGINIA
	ס		Usuel Residence of Decedent				10d. Inside City Limits
	rylan		10a. State 10b. County	10c. City, Town or Location	172	1	1 ⊠Yes 2 No
	Ba-f a	cto	MARILLAND NIA		DALTIM		119
	or 2	Director	10e. Street and Number	- D.	Of. Zip Code	0	Citizen of What Country?
	72 hours after death with the Maryland natural, or Items 23s or 28s-f show Jical Examires must be notified at	<u>a</u>	Q 10 QUEENSGA	Fyer in U.S. 13 Was	Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Rece - American Indian,
	ter de	Funeral	11. Marital Status 12. Was Decedent I Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑	lf Ye	Decedent of Hispanic Origin? (Sp.s., specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
39	urs af	<u>۾</u>	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 1 ☐ Yes 2 ☐ Nover Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Nover M	1 🗆	Yes 2 No Specify:		Specify: BLACK
0-0	a filed within 72 hours I Hygiene. other than "natural", ont, ir a Medical Exe	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent	's Usual Occupation of work done during most of work		Kind of Business/Industry
215	within 7 ene. than "r	P e	Etementary/Secondary (0-12) College (1-4or 5	life. DO I	NOT use retired)		7 / 2 / 2 8.1
21	filed wi Hygien Sther th	Co	8 THGRADE	LAC	INDRY WOO	RKER K	IGGERS LAUNDRY
- Pu	be fill	Be	17. Father's Name (First, Middle, Last)	STITI	C 14 0	O	HARVEII
2	2 should be and Mental Is marked or raumatic eve	2	19a. Informant's Name/Relationship (Type, Print)	19h Mailing A	ddress (Street and Number or Rur	al Route Number, Cit	v or Town, State, Zip Code)
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If main 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, if a Medical Examinar must be notified at		LUCY CORBETT (SIS		QUEENSGATE		LTIMORE MD 21229
9	1 and 3 Health tem 27		20a. Method of/Disposition	20b. Place of Dispositio		The state of the s	Location - City or Town, State
Baltimore,	85= 5		1 Maurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ENATIONAL 02 -	13-14 B	ATTIMARE MOTWOW
草	permit. Pa Departmer Important any injury		21. Signature of Funeral Service Licensee			ROWNJ	R. FUNERAL HOME
Ba	permit. Departr Imports any inju		Liebrenh N. Will	leans 2	148 N. FULTO	N AVE.	BALTIMORE, MD. 21217
			23a. Pert1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lit	the death. Do not enter the	ne mode of dying, such as cardiac	or respiratory arr st,	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	roscleroti.	Cardinyano	In Hear	+ Discase years
	/Medical			a consequence of):	00.00010001		The state of the s
Van S	Examiner		Sequentially list conditions b. Hype	rtunsion			
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):			
	be executed sicien and burial-transit	Kam	that intrated events	a consequence of):			
60,	be ex	alE					
687			d				
ox 6	certifi iding ise as	/Me	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant				23d. Date of delivery
΄ Β	leath cert attending	ciar	in the past 12 months? 4 Pregnant at		topic pregnancy ther (specify)		Month Day Year
D) 0.	tached	Physician/Medic	9 Unknown				
F d's	The law requires that the death certificate to has been signed by the attending phyrage 2 should be detached for use as the	by P	Part II. Other significant conditions contributing to death b	out not resulting in the unde	rlying cause given in Part I.		co use contribute to the cause of death?
0	w require been sig should b		sigmoid volvulus			1 ☐ Yes	2 No 3 Probably 4 Unknown
十 中 ecor	e law re has bed je 2 sho	Completed	Cérebra voscular a	-cident		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
R	The late had page	E O	dementia.			performed	? death? No 1 ☐ Yes 2 XNo
S is	ertificate ha	Be (25. Was case referred to medical examiner?	12000		th (Check only one)	
7	Shysica this as	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpati	1.5		ome 5 Residence 28d. Describe how in	6 Other (Specify)
	ding Ph n. Alter th funeral	lon:	27. Manner of Path 28a. Date of Inju. 1 Natural 5 □ Pending (Month, Date of Inju.)	ury 28b. Time of tniury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe flow i	ijury occurred
Division o	Attending Physician: death. ctor: Alter this certific	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e Place of In	njury - At home, farm, street,		28f. Location (Street	t and Number or Rural Route Number,
INÃ	afte Direction by	ertif	4 Homicide determined building, e	tc. (Specify)	,,,	City or Town, Si	ate)
./	To the Hospitel or attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 12 Cartifying Physician: To the best	t of my knowledge, death or	ccurred at the time, date and place	, and due to the cause	e(s) and manner as stated.
0xx	the Hos in 24 h the Fur npletely	Medical	(Check only 2 Madical Examinar: On the basis of and manner st		tigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
`	To th Withir To th comp	Ž	29b. Signature and title of certifier	′ 0	29c. License number	29d.	Date signed (Month, Day, Year)
			> Ellana Mann, M	· <i>V</i> .	100560	92 Ja	shuary 29,2004
	1	-	30. Name and address of person who completed cause of	death (Item 23a) (Type, Pri-	nt)	2011	0
-			Cano Mann	100 Co	MUN Trende	- 120UT	anuary 29,2004 mor, manyard
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regist	4Kal JUS			.21267

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 EPPELMANN 1-15A **Physician** ANDREW 01 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 73 August 051-22-1005 4 1930 New York Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other trauscass. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 12312 Shadetree Lane USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 □ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Management Analyst 12th 5+ US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sarah Day Andrew Eppelmann ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12312 Shadetree Lane, Laurel, MD 20708 Marie Eppelmann/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 6,2004 Albany, New York 4 ☐ Donation 5 ☐ Other (Specify) Bethlehem Cemetery 21. Signature of Fugeral Seption License 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00773 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or read failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY Physician /Medical Due to (or as a consequence of) SEVERAL Examiner SEPTAL ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury XFARS Due to (or as a consequence of): Completed by Physician/Medical Examiner burial-transit CORONAR The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician PERTENSION as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 5 Cher (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, DIABETES MELLITUS 1 ☐ Yes 2 No 3 Probably 4 Unknown REPAIR ATRIAL SEPTAL DEFECT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? BYPASS GRAFTS CORONARY ARTERY 2 No certificate 1 Tes 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Late of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No unerel Director: A sly filled in by the fu death. 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours att To the Funerel Di completely filled in To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21294 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDUL NAYEEM MID 3450. FOR Gause of death (Item 23a) (Type, Print) MEADE ROAD, SUITE 100, CAUREL MIS 5 31. Date filed (Month, Day, Year). 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of I	Marylan		artment o rtificate			Mental H	/giene Reg. No	$\angle UU$	L	02787
	División		Decedent's Name (First, Middle, L.	.ast)						2. Date of D Month	eath Day			3. Time of Death
	Physic /Medi		Olga Ferris							Januar			9er)4	6:45 P. M
	Exami		4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City, To	wn, or Loca	ition of Deat	h	4c.	County of	Deeth	
			Joseph Richey H	ouse			Ba1	timor	·e			1	N/A	
5	Funeral		Social Security Number 6.	Sex 7. 1 ☐ M 2 N F	Age (In yrs.	last birthday)	If Under 1 \		nder 24 Hrs urs Min.	8. Date of B	irth av. Year)	9	Birthpla	ace (State or Foreign
	Director		215-42-2334	1 L M 2 S F	59_	Yrs.				03/13				rmany
	and *		Usuel Residence of Decedent 10a. State 10b. County	-	10c Cit	y, Town or Lo	cation						10	d. Inside City Limits
	show od at	ō				,,	_						10	1 ☐ Yes 2 ☒ No
	28a-f	Director	MD Baltim 10e. Street and Number	ore			Catons							
	with						10f. Zip Co				10g. Citi	zen of Wh	at Count	ry?
	s 23	erai		PT 2-C 12. Was Decede	et Free in II	S 10.1		1228				US		1.0
	Item Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Force	s?	.5.	Yes, specify	Cuban, Me	ixican, Puer	pecify Yes or N to Rican, etc.)	0-	14. Race - Black,	White, e	
36	irs af	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Date		1	□ Yes 2 🗖	(No Spi	ecify:			Specify:		T.71 * 4
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Medical Examinar much be notified at	ed	15. Decedent's I	Education		16a, Deced	lent's Usual C	ccupation			16h Ki	nd of Busir	ness/Indi	White
7	in 7	Completed	(Specify only highest g Elementary/Secondary (0-12)		~.5.\	(Give	kind of work o	done durina	most of wo	rking	,			2011
212	filed withi Hygiene. other than	Eo	12	College (1-4	2	Homem	aker					Ow	m Ho	ome
פַ	m = 0 5	Bec	17. Father's Name (First, Middle, Las	st)				18. N	Nother's Nar	ne (First, Middle	. Maiden			
lar	should be nd Mental marked o	P P	Nicolas Lazorenk	0					Anast:	asia Cho	dach	ok		
Maryland	S DEE		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (S			iral Route Numb			ate, Zip (Code)
	1 and 2 Health a tem 27 is		Nicholas A. Ferr	is/Son		2 Ma	rathon	CT A	PT 2-0	C Balti	more	• MD	2122	28
re	s = = 0		20a. Method of Disposition			lace of Disposemetery, cren	sition (Name	of		Date		cation - Cit		
Ĕ	Pagent nt: t		1 ⅓ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		110	st Law			h2/0/	1/2004	Mar	riott	C171 1	le. MD
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Lice	epsee						wab Fur				
m	op de de de de de de de de de de de de de		- Pull	Asset						wab rui Baltin				
15	COMM.		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caus	ed the death							1110 2		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Me	1	to C	SILLES	1 C	ncev					Onser and Death
	/Medical		resulting in death)	Due to (or	as a consequ		7 (43	CO	of Ct.				-/	4 412
46	Examiner		Conventinity list conditions	b. ————										
10	D =	ner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a cons	uence of								
	ocute nd trans	Examine	that initiated events	С.										
0,	e exe ian a urial-	Ä	resulting in death) Last	Due to (or	as a consequ	uence of):								
8760,	death certificate be executed e attending physician and id for use as the burial-transit	edical		d										
9	death certifica attending ph d for use as t	Med	IF FEMALE:										-	
Box	th ce tendi	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1□Live birth			Ectopic pregn	ancv			2	3d. Date o	,	
	e des	Sici	1 Yes 2 No	4□Pregnant 9□Unknowr			Other (specif					Month	U	ay Year
P.O.	that the de led by the a detached f	>	9 Unknown					y)						
Ś	± 5 0	듄	D. 111 Other 1 - 16 - 16 - 16 - 16 - 16 - 16 - 16 -											
	res igne be	þ	Part II. Other significant conditions	contributing to death	n but not resu	ulting in the un			Part I.		0			cause of death?
ord	equires tha sen signed l lould be det	þ	Part II. Other significant conditions He jo at 1 715 C	contributing to death	n but not resu	ulting in the un			Part I.	23e. Did	0			cause of death?
ecord	law requires as been sign 2 should be	þ	Part II. Other significant conditions Heipatitis C	contributing to death	n but not resu	ulting in the un			Part I.	1 🗆 24a. Was	Yes 2	24b. Wer	Probat	oly 4 ∐Unknown
l Record	The law requires ate has been sign page 2 should be	þ	Part II. Other significant conditions He jo at 1115 C	contributing to death	n but not resu	ulting in the un			art I.	1	Yes 2 an psy prmed?	24b. Wer	Probate autops	oly 4 ∐Unknown
/ital Record	The law requires ate has been sign page 2 should be		He patitis C 25. Was case referred to medical		n but not resu	ulting in the un		e given in F		1 ☐ 24a. Was auto perfe	an psy primed?	24b. Wer	Probate autops	by 4 Unknown by findings available pletion of cause of
of Vital Record	The law requires ate has been sign page 2 should be	e Completed by	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpa	atient 2 🗆	ulting in the un	derlying caus	e given in F	Place of Dea	24a. Was auto perfo	an psy primed?	24b. Wer	Probate autops to complete 2	by 4 Unknown by findings available pletion of cause of
of Vital	Physician: The law requires this certificate has been sign ral director, page 2 should be	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death	Hospital: 1 ☐ Inpa	atient 2 🗆		derlying caus	e given in F	Place of Dea	24a. Was auto perfet 1 Yes	an psy ormed? 2 no one) dence 6	24b. Wer prior deal 1	Probate autops to complete 2	oly 4 Unknown by findings available clietion of cause of
of Vital	ding Physician: The law requires A. Her this certificate has been sign funeral director, page 2 should be	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigator	Hospital: 1 ☐ Inpa 28a. Date of Ir (Month, I	atient 2 injury Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA	26. F Other: 4 Injury at Work? 1 □ Yes	Place of Dea	24a. Was auto perfu 1 Yes	an psy ormed? 2 no one) dence 6	24b. Wer prior deal 1	Probate autops to complete 2	oly 4 Unknown by findings available clietion of cause of
vision of Vital	tending Physician: The law requires leath. for: After this cartificate has been sign for: After the funeral director, page 2 should be	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpa 28a. Date of Ir (Month. I	atient 2 injury Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA	26. F Other: 4 Injury at Work? 1 □ Yes	Place of Dea	24a. Was auto perfu 1 Yes	an posy ormed? 2 No pone) dence 6 how injury	24b. Wer prior deal 1	Probate autops r to complet? Yes 2	by 4 □Unknown by findings available bletion of cause of □ No Haspica
ivision of Vital	or Attending Physician: The law requires the death. Director: Aller this certificate has been sign in by the funeral director, page 2 should be	Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Statural 5 Pending investigative 2 Accident 3 Suicide 6 Could not determined	Hospital: 1 Inpa 28a. Date of In (Month. In 28e. Place of building,	ntient 2 injury Day Year) Injury - At ho	ER/Outpatient 28b. Time of Injury me, farm, stre	3 DOA 28c. M	26. F Other: 4 Injury at Work? 1 Yes	Place of Dea □ Nursing H 2 □ No	24a. Was auto perfu 1 Yes th (Check only ome 5 Resi 28d. Describe	an psy ormed? 2 No one) dence 6 how injury	24b. Wer prior deal 1 DOther (Probate autops are autops the complete autops the complete the complet	ely 4 Unknown by findings available pletion of cause of No Haspice Route Number,
ivision of Vital	or Attending Physician: The law requires the death. Director: Aller this certificate has been sign in by the funeral director, page 2 should be	Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 Nio 27. Manner of Death 1 Natural 5 Pending investigated investigated 4 Homicide 4 Homicide 4 Wedical Examined 5 Medical Exa	Hospital: 1 Inpa 28a. Date of Ir (Month, Ir be 28e. Place of building, chysician: To the be	atient 2 injury Day Year) Injury - At ho etc. (Specify st of my know of examinat	EP/Outpatient 28b. Time of Injury me, farm, stre	3 DOA 28c. M actiony, of	26. F Other: 4 Injury at Work? 1 Yes	Place of Dea	24a. Was auto perfect of the Check only one 5 Resi 28d. Describe	an psy primed? 2 (No one) dence 6 how injury	24b. Wer prior dead dead Control of Number of Number of State of S	Probation autops to complete 2 Probation Proba	ay findings available pletion of cause of No Haspice
Vivision of Vital	or Attending Physician: The law requires the death. Director: Aller this certificate has been sign in by the funeral director, page 2 should be	edical Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 Xio 27. Manner of Death 1 Natural 5 Pending investigation of determined 3 Suicide 6 Could not determined 29a. Certifier (Check only one)	Hospital: 1 Inpa 28a. Date of In (Month. In 28e. Place of building,	atient 2 injury Day Year) Injury - At ho etc. (Specify st of my know of examinat	EP/Outpatient 28b. Time of Injury me, farm, stre	3 DOA 28c. M et, factory, of	e given in F 26. F Other: 4 Injury at Work? 1 Yes fice	Place of Dea	24a. Was auto perfect of the Check only one 5 Resi 28d. Describe	yes 2 an psy psy primed? 2 TNo one) dence 6 how injury Street and wm, State) cause(s) date and	24b. Wer prior deat deat deat of occurred	Probate autops to compite? Yes 2 Specify) Pr Rural Properties as stated due to the	and the second of the second o
ivision of Vital	Attanding Physician: The law requires death. ectors Aller this certificate has been sign by the funeral director. page 2 should be	Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 Nio 27. Manner of Death 1 Natural 5 Pending investigated investigated 4 Homicide 4 Homicide 4 Wedical Examined 5 Medical Exa	Hospital: 1 Inpa 28a. Date of Ir (Month, Ir be 28e. Place of building, hysician: To the be	niury At ho etc. (Specify st of my know of examinat stated.	EP/Outpatient 28b. Time of Injury me, farm, stre	3 DOA 28c. M coccurred at the estigation, in the street of	26. F Other: 4 Injury at Work? 1 Yes fice	Place of Dea	24a. Was auto perfect of the Check only one 5 Resi 28d. Describe 28f. Location (City or To	yes 2 an psy psy psy psy psy psy psy psy psy psy	24b. Wer prior of death 1 Other () occurred Number of and manner place, and	Probate autops to compite? Yes 2 Specify) Pr Rural Properties as stated due to the	and the second of the second o
ivision of Vital	or Attending Physician: The law requires the death. Director: Aller this certificate has been sign in by the funeral director, page 2 should be	edical Certification; To Be Completed by	25. Was case referred to medical examiner? Yes 25 rio	Hospital: 1 Inpa 28a. Date of Ir (Month, Ir be de 28e. Place of building, Physician: To the besiminer: On the basis and manner	atient 2 injury Day Year) Injury - At ho etc. (Specify st of my know of examinat stated.	ER/Outpatient 28b. Time of Injury ime, farm, stre) wledge, death ion and/or inv	3 DOA 28c. M occurred at the estigation, in the stigation.	26. F Other: 4[Injury at Work? 1 [] Yes fice the time, data my opinion. cense numl	Place of Deal Nursing H	24a. Was auto perfect of the Check only ome 5 Resi 28d. Describe 28f. Location (City or To and due to the gred at the time,	yes 2 man psy psy psy psy psy psy psy psy psy psy	24b. Wer prior of death 1 Other () occurred Number of and manner place, and	Probate autops to compite? Yes 2 Specify) Pr Rural Properties as stated due to the	and the second of the second o
ivision of Vital	or Attending Physician: The law requires the death. Director: Aller this certificate has been sign in by the funeral director, page 2 should be	edical Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 Xio 27. Manner of Death 1 Natural 5 Pending investigation of determined 3 Suicide 6 Could not determined 29a. Certifier (Check only one)	Hospital: 1 Inpa 28a. Date of Ir (Month, Ir be de 28e. Place of building, Physician: To the besiminer: On the basis and manner	atient 2 injury Day Year) Injury - At ho etc. (Specify st of my know of examinat stated.	ER/Outpatient 28b. Time of Injury ime, farm, stre) wledge, death ion and/or inv	3 DOA 28c. M occurred at the estigation, in the stigation.	26. F Other: 4[Injury at Work? 1 [] Yes fice the time, data my opinion. cense numl	Place of Deal Nursing H	24a. Was auto perfect of the Check only ome 5 Resi 28d. Describe 28f. Location (City or To and due to the gred at the time,	yes 2 man psy psy psy psy psy psy psy psy psy psy	24b. Wer prior of death 1 Other () occurred Number of and manner place, and	Probate autops to compite? Yes 2 Specify) Pr Rural Properties as stated due to the	and the second of the second o
ivision of Vital	or Attending Physician: The law requires the death. Director: Aller this certificate has been sign in by the funeral director, page 2 should be	Medical Certification; To Be Completed by	25. Was case referred to medical examiner? Yes 25 rio	Hospital: 1 Inpa 28a. Date of Ir (Month, I) 28e. Place of building, thysician: To the beaminer: On the basis and manner Completed cause of Ir	atient 2 injury Day Year) Injury - At ho etc. (Specify st of my know of examinat stated.	EP/Outpatient 28b. Time of Injury me, farm, stre wledge, death ion and/or inv 23a) (Type, F	3 DOA 28c. M occurred at the estigation, in the stigation.	26. F Other: 4[Injury at Work? 1 [] Yes fice the time, data my opinion. cense numl	Place of Deal Nursing H	24a. Was auto perfect of the Check only one 5 Resi 28d. Describe 28f. Location (City or To	yes 2 man psy psy psy psy psy psy psy psy psy psy	24b. Wer prior of death 1 Other () occurred Number of and manner place, and	Probate autops to compite? Yes 2 Specify) Pr Rural Properties as stated due to the	and the second of the second o

31,2004

LANUARY

OLGA FORFIC

			State of Maryland	I / Denartment of	Health and	Mental Hy	giona	
	1	For State Registrar	State of Maryland	Certificate o		-		4 0-278
		1. Decedent's Name (First, Middle, Last) (_	2. Date of Dea	ath	3. Time of Death
hysician /Medical	-	William t	t. Freder	-ick 3	50	Janua	Day Yes	
Examiner		la. Facility Name (If not institution, give			, or Location of Deat		4c. County of D	
		do Millwhee	1 Court	Bat	timor		Baltin	
ineral		5. Social Security Number 6. Se	THE OF I	st birthday) If Under 1 Ye. Months Day		(Month, Da	th y, Year)	Birthplace (State or Fore Country) TYLANd
rector	-	Q18-38-3925 1L Usual Residence of Decedent	62	115.		Sept. 1	1,1941 Ma	rykana
Mo =	- 1	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Lim
in the second	2	Maryland Baltimor	e	Baltim	ore			1 □ Yes 2 ∑]!
or 28.	<u> </u>	10e. Street and Number	· · ·	10f. Zip Code	9		10g. Citizen of What	Country?
ortant: if item 27 is marked other then "naturel", or lieme 23e or 28e-f show injury or other treumatic event, the Mudical Examinar must be notified at 8. To Re Completed by Funeral Director	Ē _	66 Millwheel Ct.			21236		U.S.A	
emet Fire	2	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Decedent of If Yes, specify C	f Hispanic Origin? (S uban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	- 14. Race - A Black, W	merican Indian, /hite, etc.
xerri	<u>ל</u>	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yès, Give Year or Dates: Victna	1 ☐ Yes 2 💢 N	lo Specify:		Specify:	White
Sale S	3	15. Decedent's Edu	cation	16a. Decedent's Usual Occ	cupation	i	16b. Kind of Busine	ss/Industry
t, the Medical E	1	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give kind of work doi life. DO NOT use ret	ne during most of wor ired)	rking		
đị c	5	12th Grade	55.10g5 (1 45.101)	Operating 1	ngineer		Local 3	7
event Re G	0	17. Father's Name (First, Middle, Last)	+				Maiden Sumame)	
atic	2	William Harrison	Frederick		Myr	tle Mae	Biles	
une.	1	19a. Informant's Name/Relationship (T)		19b. Mailing Address (Stre				
thert	-	Mrs. Damarys Fred		66 Millwheel ce of Disposition (Name of		timore,		
0		1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State	netery, crematory or other p	olace)		20c. Location - City	
njury	1	' 4 ☐ Donation 5 ☐ Other (Specify)		view Cremator	Ly 2/4	/2004	Baltimore	, Maryland
any injury or		21. Operation of Funery Service Licens	M. K	0705 Pal	aress or Facility Sc	himunek Paltimat	Funeral H	omes
	+	23a. Part1. Enter the disease, or comp	lications that caused the death		Pair Rd.,			236 Approximate
		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.		,,,,		.00.,	Interval Between Onset and Death
cian lical	ĺ	disease or condition resulting in death)	a. COPD Due to (or as a conseque	anno offi				-
iner			Multiple	Sclerosi	5			
ةِ	<u> </u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque					
Examiner		Cause. Enter Underlying Cause (Disease or injury that initiated events	с.					4
urial-l	í	resulting in death) Last	Due to (or as a conseque	ence of):				
the but			d					- W
d be detached for use as the burial-transit by Physician/Medical Examir	É	IF FEMALE:	23c. If yes, outcome of pregnance			-		
for us		in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3 Ectopic pregnar			23d. Date of o Month	delivery Day Year
ched vs.ic	2	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	un 3 🗆 Other (specily)				
deta		Part II. Other significent conditions co	ntributing to death but not result	ing in the underlying cause	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
yd be	2					1 🗆 Y	′es 2 □ No 3	Probably 4 Unkno
page 2 should Completed						24a. Was		autopsy findings availa
page 2	[autop perfor	rmed? prior i 2.23 No 1 ☐ Y	
5 O	0	25. Was case referred to medical		1-1	26. Place of Dea	ith (Check only o		03 20110
io o		examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient 3 □ DOA	Other: 4 Nursing H	ome 5 Resid	lence 6 Other (S	pecify)
director		27. Manper of Death	28a. Date of Injury 2 (Month, Day Year)	8b. Time of 128c. In Injury	jury at York?	28d. Describe h	ow injury occurred	
	2	• /			☐ Yes 2 ☐ No			
ineral di	2	1 Natural 5 Pending investigation	- 1		10	28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,
ineral dii	2	1 Natural 5 ☐ Pending	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office				
ineral dii	Columbanion, 10	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)	•	1			
ineral di	Columbanion, 10	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 1 Pending investigation 6 Could not be determined	building, etc. (Specify) sicien: To the best of my knowl ner: On the basis of examinatio	ledge, death occurred at the	time, date and place y opinion, death occu	, and due to the o	cause(s) and manner date and place, and c	as stated. due to the cause(s)
ineral di	edical certification, 10	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 25 Pending investigation 6 Could not be determined	building, etc. (Specify) sicien: To the best of my knowl	ledge, death occurred at the en and/or investigation, in m	time, date and place y opinion, death occu	rred at the time, o	cause(s) and manner date and place, and d 29d. Date signed (Mo	due to the cause(s)
ineral di	edical certification, 10	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Specify) sicien: To the best of my knowl ner: On the basis of examinatio	ledge, death occurred at the n and/or investigation, in m	y opinion, death occu	rred at the time, o	date and place, and d	due to the cause(s)
ineral di		1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	sicien: To the best of my knowl ner: On the basis of examinatio and manner stated.	ledge, death occurred at the nand/or investigation, in m	y opinion, death occu	rred at the time, o	date and place, and o	due to the cause(s)
Atter th funeral		1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	sicien: To the best of my knowl ner: On the basis of examination and manner stated.	ledge, death occurred at the on and/or investigation, in modern and/or investigation and i	y opinion, death occurring number	rred at the time, o	date and place, and d	due to the cause(s)

			- FOI	tate of Maryland	Department of Health and M Certificate of Death		_ / U II II	02789
	and a		State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. 2. Date of Death	No.	3. Time of Death
	Physici		A A .	Sathrum F	arinholt		Day Year	2:09 AM
	/Medic Examin		4a. Facility Name (If not institution, give stree		4b. City, Town, or Location of Death	0.011	4c. County of Death	
			Gilchrist		Towson		Baltin	nove
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	9. Birth	place (Stete or Foreign
	Director		Usual Residence of Decedent	2XF 78	115.	SEP 1 1	7 05	PA
	/land		10a. State 10b. County	10c. City, T	own or Location			Od. Inside City Limits
	Many a-f sh	tor	MD Baltimo	re	Cockeusuille			1 XYes 2 □ No
	th the or 284	Director	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Cou	ntry?
	23a	rai	13801 York Ad). Apt. A14	91030		USA	
	er de	Funeral		Was Decedent Ever in U.S. Armed Forces? □ Yes 2 XNo	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White,	
36	irs aft	by F	re	f Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	hite
9-0-	72 hours after death with the Maryland natural; or Items 23a or 28a-f show dical Examinar must be nutilied at	Completed	15. Decedent's Education (Specify only highest grade control		6a. Decedent's Usual Occupation (Give kind of work done during most of work)	160	b. Kind of Business/In	dustry
21	ithin 7	npie		College (1-4or 5+)	life. DO NOT use retired)	9	- \	
2	lled w tygier her th	ပိ	17. Father's Name (First, Middle, Last)	4	leacher	e (First, Middle, Mai	Foucat	ion
anc	d be findal h	Be	4.		M	1 L	C	60000
Maryland 21215-0036	should Me mark	ဍ	Elmer Snuder 19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing Address (Street and Number of Rura	Il Route Number, C	ity or Town, State, Zip	Code)
ž	nd 2 aith a 27 is 27 is		Kathrun Farinba		4821 Keswick Bd 1	Baltimo		Olei
Ţ.	of Head		20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Remo	20b. Place			c. Location - City or To	own, Stete
A. A.M. Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, Ite Madical Examinar must be nutilised at once.		'4 □Donation 5 □ Other (Specify)		V. 1 C. 1 C. 1 C. 1	-04 F	Saltimore	mD
3alt	ermit. epart nport ny inj		21. Signature of Funeral Service Licen e) ,	22. Name and Address of Facility	Α:) 11	~ =	2.4.0
. 0	00 F 4 0		Janvil 1	nach			Dr. Jessu	Approximate
			shock sheart failure. List only one commediate cause (Final	1/- 11	Do not enter the mode of dying, such as cardiac of		'	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	MON- Ho		MA	1	years
-	Examiner			Due to (or as a consequen	Ce 01):			J
40		ē	Sa uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ce oi):			
36	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last					
	cate be executed physician and the burial-transit	E	resulting in Geauty Last	Due to (or as a consequen	ce of):			
98760	physics the k	dicai	d					
5)8	th certifi ending r use as	/Me		f yes, outcome of pregnancy			23d. Date of deliv	erv
B/A	that the death certified by the attending of detached for use as	Physician/Me	in the past 12 months?	1□Live birth 2□Fetel de 4□Pregnant at time ol death			Month	Day Year
00	t the by the tacher	hys	9 □ Unknown	9□ Unknown				
2 5	res that igned by be deta	by P	Part II. Other significant conditions contrib	uting to death but not resulting	ng in the underlying cause given in Part I.		co use contribute to t	
ord	aw requires ts been sign 2 should be	ted				1 Yes	2 ∑ No 3 ☐ Prol	oably 4 Unknown
Tec +	aw 2 sib	Completed				24a. Was an autopsy performed	prior to co	ppsy findings available impletion of cause of
tal F	(Q CT					1 □ Yes 2 🔀	TNo 1 ☐ Yes	2 No
< !	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No Hosp	ital: 1 ☐ Inpatient 2 ☐ ER	Other	n (Check only one)	e 6 X Other (Speci	Hacalca
()	g Phys er this eral di	n; To	27. Manner of Death 2		b. Time of 28c. Injury at	28d. Describe how		" Crop =
io io	Attending Ir death.	atio	1 Natural 5 Pending 2 Accident investigation	(Monal, Day 16a)	Injury Work? M 1 ☐ Yes 2 ☐ No			
Division	r Atterde	Certification;	3 Suicide 6 Could not be determined	 Place of Injury - At home building, etc. (Specify) 	e, farm, street, factory, office	28I. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
<u></u> Ω	Hospital or te hours after Funeral Dir tely filled in		00 0 W 4 D 0 W 1 D 1 D	7.16.16.16.1			- (-)	
de la	Hospital or Attend 24 hours after death Funeral Director: etely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physicial (Check only one)	In: 10 the best of my knowle On the basis of examination and manner stated.	dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	ed at the time, date	se(s) and manner as s and place, and due t	tated. the cause(s)
,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	•	29c. License number	29d.	. Date signed (Month,	Dey, Year)
	->-0		A Anthon	lila, my	D25205	Ja	m26,2	304
	n		30. Name and address of person who compl	eted ca So of death (Item 23	Dasdos N. Charles St. B	0.0	17175	
-			W.A. Riley GBI	mc 6701	N. Charles D. B	acro. M	N X140	<i>Y</i>
	Sta Regist		31. Date filed (Month, Day, Year) FFR 0 3 2004	32. Registrar's Signature	Annel.			

ORIGINAL

Dhyois	25	Decedent's Name (First, Middle, L.	•	4/th: 1H.C	alo oi boulli	Reg. 2. Date of Death Month	Day Year	3. Time of Death
Physic /Medi			lora			January 3	30, 2004	2:05 AM
Exami	ner	4a. Facility Name (If not institution, gi Ivy Hall Center		4b. C	ity, Town, or Location of Dea	ath	4c. County of Death	
			Sex 7. Age (In yrs. last		iddle River der 1 Year If Under 24 Hi	s. 8. Date of Birth	Balt	imore
Funeral Director			1□ M 2√F 91	Yrs. Mont			1912 Mar	nplace (State or Fore unity) Vland
· >		Usual Residence of Decedent	10-01-7					
shov	5	10a. State 10b. County	Toc. City, 1	own or Location				10d. fnside City Lim 17€Yes 2 □
28a-f	ecto	40. 0	ore N/A	Middle			Civi (1)M/h C	
8 01	Funeral Director		37th STREET	101.	Zip Code		. Citizen of What Col USA	unity :
ns 23	era	1300 Winlass Dri	12. Was Decedent Ever in U.S.	13. Was De	2120 212		14. Race - Amer	ican Indian,
al de	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		cedent of Hispanic Origin? (specify Cuban, Mexican, Pue	erto Rican, etc.)	Bfack, White	
ital Hygiene. Id other than "naturel", or itams 23a or 28a-f show event, the Medical Examiner must be molified at	l by	3,∏Widowed 4 □ Divorced	It Yes, Give Year or Dates:	1 □ Yes	s 2. No Specify:		Specify: Wh	ite
natural, or itama 23a or 28a-1 show	Completed	15. Decedent's E (Specify only highest gi	ducation 1 ade completed)	6a. Decedent's U (Give kind of	isual Occupation work done during most of w Tuse retired)	orking 16t	b. Kind of Business/I	ndustry
than the Med	dm	Efementary/Secondary (0-12)	College (1-4or 5+)				-	0
and Mental Hygiene. is marked other than sumatic event, the M		Unknown 17. Father's Name (First, Middle, Las		worked 3	uspense Desk	ame (First, Middle, Mai	Insurance	Company
ked o	To Be	Unknown			Mary 1			
f Health and Menta Item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maifing Addr	ess (Street and Number or I			ip Code)
12 E		Christine Davis	Niece	12541 Gr	acewood Drive	Baltimor	e. Maryla	nd 21220
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [20b. Place	e of Disposition (i	Name of or other place)		c. Location - City or 1	Town, State
ortant: If it injury or o		`4 □Donation 5 □ Other (Spec	Park	wood Cem	etery 2/3/	/2004 Pa	rkville.	Maryland
Department of important: If it is eny injury or conce.		21. Signature of Juneral Service Lice	nsee A	22. Name	and Address of Facility			
. O 5 8 0		Jum 1). Henss	3631	ee-пenss-seit Falls Road,	z runeral Baltimore.	Home, Inc Maryland	. 21211
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	one cause on each fine.	o not enter the n	node of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
hysician Medical		fmmediate Cause (Final disease or condition resulting in death)	a. Cerebro	vanu	on ace	ident		1,000
kaminer			Due to (or as a consequen	ce of):				
	Jer .	Gequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):				
ician and burial-transit	Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c Prog	CATUR	delis	re		
ian al urial-t		resulting in death) Last	Due to (or as a consequen	ce of):				
S 0	dlcai		d					
ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy					
ite has been signed by the attending phoage 2 should be detached for use as th	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal de 4 Pregnant at time of death	ath 3 □Ectopic	pregnancy (specify)		23d. Date of delik Month	ory Day Year
by the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	, 50,000	(0000.1)			
igned b	by PI	Part II. Other significent conditions	contributing to death but not resulting	ig in the underlyin	g cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death
been sig should b						1 🗀 Yes	2 □ No 3 □ Pro	babíy 4 Unkno
has bei je 2 sho	Completed					24a. Was an autopsy	24b. Were aut	opsy findings availa
ate ha	Mo					performed	death?	2 No
certificate rector. pag	Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
this ce al dire	2	1 ☐ Yes 2 ☐ NO	1			Home 5 ☐ Residence		ify)
	ion	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	(Month, Day Yeer)	b. Time of Injury	28c. Injury at Work?	28d. Describe how i	njury occurred	
	Certification;	2 Accident investigation 3 Suicide 6 Could not I	De Goo Stop of Laive, At home	M street fac	1 Yes 2 No	28f Location (Stree	t and Number or Rui	m I Pouta Number
death	ertif	4 ☐ Homicide determined	building, etc. (Specify)	, iaiiii, stieet, iac	ory, once	City or Town, S		ai noute ivuinder,
after death. Diractor: A in by the fu	10	29a. Certifier 1 Sertifying P	hysicien: To the best of my knowled	dge, death occurr	ed at the time, date and place	ce, and due to the caus	e(s) and manner as	stated.
iours after death. Ineral Director: After filled in by the funera			miner: On the basis of examination	and/or investigat	ion, in my opinion, death occ	curred at the time, date	and place, and due	to the cause(s)
s 24 hours after death be Funeral Diractor: tetaly filled in by the		(Check only 2 Medical Exe	and manner stated.					
within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical ((Check only 2 Medical Exe	and manner stated.		29c. License number	29d.	Date signed (Month,	Day, Year)
4 hours Funera		(Check only 2 Medical Exe	and manner stated.		D 31 4 6 4	29d.	Date signed (Month)	, Day, Year)
within 24 hours after deatl To the Funeral Director: completely filled in by the		(Check only 2 Medical Exe	and manner stated.)			1/30/0	Day, Year)

		-	For State Registrar	State of Maryl		epartment of He Certificate of L		Re	19. No. 2 U U 4	02791
	Physicia	ın	1. Decedent's Name (First, Middle, Last) HARRY EDWAR	D FIELDS				2. Date of Death Month	Day Year	3. Time of Death 3:45 PM
×.	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give s FRANKI'N SQUAR 5. Social Security Number 6. Sex 215-16-2841	E Hospit	yrs. last birth	4b. City, Town, or ROSE If Under 1 Year Months Days	1 1	8. Date of Birth (Month, Day, April 22	4c. County of Death 3	MORE Inplace (State or Foreign intry) Aryland
	and #		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town	or Location				10d. Inside City Limits
	a-f ehc	ctor	Maryland Baltimor	e	Par	kville				1 ☐ Yes 2 🐧 No
	with the	Dire	10e. Street and Number 9031-A Simms Aven	110		10f. Zip Code 212	.34	10	og. Citizen of What Co U.S.A.	untry?
98	s I and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Other traumatic event, the Modical Examinar must be notified at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces? 1 Xyes 2 No 11 Yes, Give Year or Dates: 1946		13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecrfy Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	e, etc.
9	2 hours etural', ical Ex	ted by	3 Widowed 4 Divorced 15. Decedent's Edu	cation	16a. l	Decedent's Usual Occupa (Give kind of work done d	ition		16b. Kind of Business/	
Maryland 21215-0036	within 7 ene. than "n	Completed	(Specify only highest grade	College (1-4or 5+)	'	Proprietor)	9	Tavern	
λd 2	e filed within at Hygiene. I other than 'vent, it e Me	Be Co	17. Father's Name (First, Middle, Last)		!	TTOPTICOOT	18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
ylar	should be ind Mentat marked o umatic eve	To	John Herman Fie		10h	Mailing Address (Street a			McCubbin City or Town State 7	(in Code)
Mar	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship (Ty) Doris S. Fields	(wife)					e, Marylan	
Baltimore,	95		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ R 1 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Disposition (Name of r, crematory or other place Mount Cremat	I		20c.Location-City or Baltimore,	
Balti	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service License	an		Mitchell-W 6500 York	is of Facility iedefeld Road Ba	Funeral ltimore,	Home, Inc Maryland	
	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or complisheck, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ications that caused the ne cause on each line. Due to (or as a cor Due to (or as a cor Due to (or as a cor	nsequence o	r):	g, such as cardiac	or respiratory arre	est,	Approximate Interval Belween Onset and Death
68760,	icate be executed physician and s the burial-transit	edical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	COPI) rj:				
P.O. Box (The law requires that the death certifiate has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	•		23d. Date of del Month	ivery Day Year
	quires that the de n signed by the a uld be detached t	þ	Part II. Other significent conditions con	-			en in Part I.	23e. Did tol	bacco use contribute to es 2 □ No 3 □ Pr	the cause of death?
of Vital Records,	The law require cate has been sig page 2 should b	Completed						24a. Was a autops perform	med? prior to death?	atopsy findings available completion of cause of 2 No
Vita	ysician: The is certificate hidirector, page	o Be	25. Was case referred to medical examiner?	Hospital: 1 Minpatient	2 🗆 ER/Out	tpatient 3 DOA Oth		th <i>Check onl</i> on ome 5 ☐ Reside	ence 6 □Other (Spe	cify)
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. T	ime of 28c. Injury	v at		ow injury occurred	
Division	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor; After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, fa	rm, street, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ural Route Number,
7	Hospi 24 hour Funar stely fill	Medical	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my iner: On the basis of exa and manner stated.	mination and	, death occurred at the tind d/or investigation, in my o	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manner as late and place, and due	s stated. to the cause(s)
Ì	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed (Mont	h, Day, Year)
7	W -		1 (Jokones	HO		Res	0000		1/2+104	
	m		DR, Behzad OSK	ompleted cause of death	(Item 23a) (NKIN SO	YARE D	R. BAI	TIMOREI	Md. 21237
<i>3</i> *	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	aste)				Md, 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

	•	1 - For State Registrar	State of Maryla		rtificate of			eg. No.	UUU	06126
81.0	6.4	Decedent's Name (First, Middle, Last,)				2. Date of Deat		Year	3. Time of Death
Physic		Mae R.	De Francis				Jan. 23	. 2004		10:35 P M
/Medi Examii		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death		,	nty of Death	
E Adrim		Stella Maris	Hospice		Ti	monium			Balti	more
Funeral	W 75 CA	5. Social Security Number 6. Se	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Vaarl		place (State or Foreign
Director		103-24-4898]M 2 ⊠ F	76 Yrs.	Months Days	Hours Min.	May 31,		New	
p s] }	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City Limits
anyla sho	2			, , , , , , , , , , , , , , , , , , ,	out.or.					1 ☐ Yes 2√No
Ba-f	ecto	Md. Baltim	ore		uthervill	e		On Citiens	of What Cou	
vith th	Dic	10e. Street and Number	_		10f. Zip Code		"	og. Citizen		nuy?
ath v 8 238	a	3303 Bridle Rid				1093		14.6	USA Race - Ameri	ann Indian
er de Item	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	0.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exercities multiped at once.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1□Yes 2√No	Specify:		Spe	cify:	White
hour Hours		15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation	· · · · · · · · · · · · · · · · · · ·	16b. Kind o	f Business/Ir	
in 72 in case	plet	(Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	durina most of work	king			
i with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		Homemak	er		0	Jwn_Ho	me .
Hyg othe	0	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M			
id be ked a	To B	August Lasco	la			Sara	a Pierri			
should nd Men is marke	-	19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Street			City or To	wn, State, Zij	Code)
and 2 ealth a m 27 is		Mrs. Karin De Fran	cis/Daughter	3303	Bridle Ri	die Lane	Juthery	/ille.	Mary	land 21093
Head the other		20a. Method of Disposition	20b.	Place of Dispe	osition (Name of matory or other place	-			on - City or T	
mit. Pages partment of I portant: If it y injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		, , ,		1	/20 /0/.	-		and and
artme artme ortan injur		21. Signature of Funeral Service Ligens			alley Mem 2. Name and Addre					Home, Inc.
permit. Departition of the permit of the per		mil. VA	0.26	1	050 York		uson, Mar			•
		23a. Part1. Enter the disease, or comp	lications that caused the de							Approximate Interval Between
200		shock, or heart failure. List only o Immediate Cause (Final								Onset and Death
Physician /Medical		disease or condition resulting in death)	a. END STAGI Due to (or as a conse		IMER S				-	
Examiner			Due to (or as a conse	oquorico cr).						
<u> </u>	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse	equence of):						
uted	퉅	Cause (Disease or injury								
exector and and ial-tra	Examiner	resulting in death) Last	Due to (or as a conse	equence of):						
oof ou, tificate be executed ig physician and as the burial-transit	ledical	(d							
ற் திறை எ	ed									
wrequires that the death cerbeen signed by the attendin should be detached for use	N/U	230. was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		□Ectopic pregnancy	,		23d.	Date of deliv	
The COLOS, F.O. BOX The law requires that the death cer the has been signed by the attendir sage 2 should be detached for use	Physician/N	in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No	4☐Pregnant at time of		Other (specify)				Month	Day Year
by th	hys	9 Unknown	9LI ONKNOWN					-		
s tha	by F	Part II. Other significant conditions co	ntributing to death but not re	esulting in the t	anderlying cause giv	ren in Part I.	23e. Did tob	pacco use c	ontribute to	the cause of death?
w requires been sign should be							1 □ Y€	es 2□No	o 3∏Pro	bably 4 Dunknown
aw re	plet						24a. Was a autops		b. Were aut	opsy findings available ompletion of cause of
The law	Completed						perform	ned?	death?	2 No
	0	25. Was case referred to medical				26. Place of Dea	th (Check only on			
OI VICA Physician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing H	ome 5 Reside	ence 6 👿	Other (Speci	(y) HOSPICE
on or	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		y at	28d. Describe ho			
Attending I ar death. ector: After by the funer	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(,,	,		Yes 2 □ No				
OVISION Tor Attending after death. Director: After in by the function	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, factory, office		28f. Location (St City or Town		mber or Rur	al Route Number,
tal or is after all Dir	Çe								<u>.</u>	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	cal	(Check only 2 Medical Exam	rsician: To the best of my kiner: On the basis of exami	nowledge, dea nation and/or in	th occurred at the time	me, date and place, ppinion, death occur	, and due to the carred at the time, d	ause(s) and ate and plac	manner as see, and due to	stated. o the cause(s)
the Hain 24 the F	Medical	one)	and manner stated.		70e Licens	o numbor	2	Od Data sir	and (Manth	Day Vass)
To with	2	29b. Signature and the of certifier	M ~		29c. Licens	ופטווטוו פו	2	•	gned (Month,	
6			·			1717		1	126,	164
r)		30. Name and address of person who c								
		DR. TARIO MAHMOO 31. Date filed (Month, Day, Year)				TIMONIUM,	, MD 2109) 3		
Si Regis	ate trar	red (3 2004 Sig	we &	proces	y				
1.10910		tro v	9 0000							

DHMH 17 Rev 1/2001

10:35 р.ш.

JANUARY 23, 2004

MAE DeFRANCIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day **Physician** Frank January 28 01:20 P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 28, Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Months Hours 1**X**□M 2□F 60 060-36-8131 1943 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ir than "natural", or Items 23a or 28a-f ahow the Medical Examinar must be nutified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Millersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 854 Oakdale Circle 21108 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) Electronic Engineer NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mental I ant: if Item 27 is marked o John Wyman Frank, Sr. Ann Beatrice Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 854 Oakdale Circle Millersville, MD Mrs. Carol A. Frank / Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Cometan, crematory or other place)

Glen Haven Memorial Park 2004 FeBate 2 permit. Pages 1 Department of H Important: if Ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, P.A. Glen Burnie, MD 21. Signature of Funeral Service Licensee 200303 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition THIOBLASTOM 13 HONTHS Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed and Due to (or as a consequence of): the attending physicien Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No l or Attend after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital a within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STUART A. Jahrs

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 2

644

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

ORIGINAL

32. Registrar's Signature

		•	1 - For Amend Items 23a	State of Ma ,27,28a-f pe	arylancer ME,	/ Depart -829_03/2 Certif	ment of H 3/04dhb icate of L	lealth and Death	Mental Hy	giene Reg. No.	004	02794
			1. Decedent's Name (First, Middle, Las						2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		JAMES (1 ASK	Y (TA ET	NE	R			JANUAR		2004	11/0A.M
	Examin		4a. Facility Name (If not institution, give	street and number)		41	c. City, Town, or	Location of Dea	ith	4c. Co	unty of Deeth	
			1216 MAIS	DER Ch	BICE	LANG	CATO	N5014	-LE	-	747/1	
	Funeral		5. Social Security Number 6. Se	X 7. Agi SIM 2□F			Under 1 Year ionths Days	If Under 24 Hr Hours Mir	(Month, Da	y, Year)	Cour	
	Director		219-32-7681 Usual Residence of Decedent		68	113.			08/16/1	935	MI)
	and and		10a. State 10b. County		10c. City,	Town or Locati	on				1	0d. Inside City Limits
	Mary f sh	Ď	MD Baltimo	ro	Δ.	rbutus					İ	1 ☐ Yes 2 🛣 No
	the	rec	10e. Street and Number	16	A		10f. Zip Code			10g. Citizen	of What Cour	ntry?
	3e ou	Funeral Director	1216 Maiden Choic	o I ano			21	229			USA	
	death rms 2	nera	11. Marital Status	12. Was Decedent	Ever in U.S	i. 13. Was	Decedent of H		Specify Yes or No		Race - Amend Black, White,	
9	after or Ite	Ē	1 ⊠.Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 3.1 If Yes, Give	No	1	Yes 2X No	Specify:	ito mean, etc.,		ecify:	etc.
21215-0036	72 hours after death with the Maryland naturel; or ltems 23e or 28e-f show Jical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:			703 2,24110			36		White
ς. Υ	72 h	Completed	15. Decedent's Ed (Specify only highest grade)			(Give kin	t's Usual Occupa d of work done o	during most of w	orking	16b. Kind o	of Business/In	dustry
12	within iene. then "	m p	Elementary/Secondary (0-12)	College (1-4or 5	5+)		NOT use retired	")				2.11.
2	filed v Hygie other t		17. Father's Name (First, Middle, Last)	1		Super	visor	18. Mother's N	ame (First, Middle,			Credit
anc	ntal hed of	Be c										
Maryland	should to nd Ment marked umatic	ဥ	Irvin T. Gardner	voe Print)	-	19b. Mailing A	Address (Street a		Madeline Rural Route Numbe			Code)
⊠	01 10 10 10		Mary Matheny/Sist				Northwa		timore, M			
<u>6</u>	tem 27 to other tr		20a. Method of Disposition	C.I.	20b. Pla	ace of Disposition	on (Name of		Date		on - City or To	own, State
Baltimore,	e = 5		1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			•		etery 0	1/29/04	Balt:	imore,	MD
Ħ	Department Department Important: eny injury once.		21. Signature of Fune al Service Licen		THE W				chwab Fun			
m	Depa Impo eny ii		Totalin						nwab run Baltim			
	# P		23a. Part 1. Epter the disease, or companies shock, or beart failure. List only	plications that caused one cause on each li	the death.	Do not enter t	he made of dvin	g, such as cardi	ac or respiratory ar			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a ATTARO		-	/ - / -	pr 5001/1	()	1.15 1	1	Inset and Death
2	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of): Com	plicating	Hypother		1111	/ /	
Ģ.	LXUIIIIICI		Sequentially list conditions, if any, leading to immediate	b. Due to (or as	0.0000000	anna of\:	· · · · · · · · · · · · · · · · · · ·	- A	NA PORNIED BY WE	1	IFR .	
	bed isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	erice or).			N Lay WE	OCAL EXAMI		
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	C Due to (or as	a consequ	ence of):		-moute	M 1000 (NED D			
8760,	ate be executed hysician and the burial-transit	lcal E		d				CERTIFICA				
687	death certificate e attending phys d for use as the	edlo		. 0.			-					
Вох	leath certifica attending ph I for use as th	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of delive	эгу
ă	death a atte	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			topic pregnancy ther (s <i>pecify)</i>				Month	Day Year
P.0	by th	Physician/Med	9 Unknown	9□ Unknown								
	S C 0	by P	Part II. Other significant conditions of	ontributing to death b	ut not resu	lting in the unde	rlying cause give	en in Part I.	23e. Did to	obacco use		he cause of death?
Vital Records,	w requires been sign should be								10'	res 2□N	o 3 Prot	pably 4 Mknown
၁၁	law as b 2 sl	Completed							24a. Was		4b. Were auto	psy findings available mpletion of cause of
ž	: The cate has page	E O							perfo	rmed? 2₽No	death?	· —
ita	ysicien: is certifica director, I	Be C	25. Was case referred to medical examiner?					26. Place of D	eath (Check only o	ne)		
of <		2	1 Nes 2 No	Hospital: 1 Inpatie			3 DOA Oth	4 🗀 Nursing	Home 5 Resid			y)
u c	ding Ph h. After th funeral	.: 0	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Injun Wor	y at k?	Subject o			ontri ronmont
sio	Attending r death. ector: After by the fune	cat	2X Accident investigation 3 ☐ Suicide 6 ☐ Could not be	01/2		11	4	Yes 2 No	_			environment
Division	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Inj building, et			, factory, office		City or Tov	vn, State)	Catonsvi	al Route Number, i.11e,MD
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	SalCe	29a. Certifier 1 Certifying Ph	ysician: To the best niner: On the basis o	of my know	me viedge, death o	courred at the tin	ne, date and pla	1216 Maid	cause(s) and	manner as s	tated.
	the H iin 24 the Fi iplete	ledical	one)	and manner st								
	Vitt To COT	Σ	29b. Signature and title of certifier				29c. Licens	e number		290. Date si	gned (Month,	5-2004
			7747110	c lemon	UI	n.P.	1	1117	,	741/01	1	
	φ		30. Name and address of person who		SGZ	23a) (Type, Pri	nt)	100	6/11-		2: 1	01/-
			31. Date filed (Month, Day, Year)	So , √ 1 32. Registr	1	ure	" 11 IV/ .	MNE	14,00	TT	17711	Day, Year) 5,2004 1RAYLAND
10	Sta Regist		Si. Date filed (Montal, Day, 16a)	6		to Ano	100					

	State of Maryland / Department of Health and Me State Certificate of Death	Reg. No.
Physician	I. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death Month Jan 28 2004 1:15 A
/Medical Examiner Funeral	Morningside Assisted Living Filicott City Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min.	4c. County of Death Howard 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Director	16 0 12 8329 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Mar. 25,1906Missouri 10d. Inside City Limits 1 □ Yes 🛣 No
or 28e-1 s	MD Howard Ellicott City 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
ire, Maryland Z I Z I 3-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental hygiene. stem 27 is marked other than "natural; or items 23s or 28s-1 show other treumatic event, the Medical Exacting must be invilled at other treumatic event, the Medical Exacting must be invilled at To Re Completed by Funeral Director	5330 Dorsey Hall Drive # 111 21042 11. Marital Status 1 Never Married 2 Married al Divorced 1 Never Married al Divorced	
ed within 72 hours at vgiene. rer than "natural; or it, the Medical Exact Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of works) (ife. DO NOT use retired) Business Owner	Pure Natural Water (First, Middle, Maiden Sumame)
To should be filed within 7 is marked other than 7 is marked other than 1 it reumalic event, I a Mes	Harrison F. Gleason Sadie Fa	arnsworth
Saltimore, Mai yiaila semit. Pages 1 and 2 should be file Separtment of Heelth and Mental by mportant: If item 27 is marked oth my injury or other treumatic even anse.	19a. Informant's Name/Relationship (Type, Print) Cathy Lundy/daughter 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 1 Donation 5 Other (Specify) 19b. Mailing Address (Street and Number or Rural 10406 Queens Way D 1 Cathy Lundy/daughter 20b. Place of Disposition (Name of cametery, crematory or other place) 1 Balto/Wash.Crematory	
Definition Pages Department of Important: If its any injury or or or once.	4 Doriation 5 Donier (-)	tzke Funeral Homes, Inc. Rd., Columbia, Md. 2104 or respiratory arrest, Approximate Interval Between Onset and Death Vec (S
68760, utilicate be executed was physicien and as the burial-transit	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	
of Vital Hecords, P.O. Box 68 Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
ires that the signed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
The law requir	ВРН	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
Division of Vital Records, to Attending Physician: The law requires that death. Director: Atten this certificate has been signed in by the funeral director, page 2 should be continued.	25. Was case referred to medical examiner? 1 Yes 2 No	Ath (Check only one) Home 5 Residence 6 Ather (Specify Assiste 28d. Describe how injury occurred Living
Division To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely (illed in by the funer	2 Accident investigation 3 Suicide 6 Could not be determined 28s. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours a To the Funerel I completely filled	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 29b. Signature and Teleph-extifier 29c. License number	29d. Date signed (Month, Day, Year)
p z z z s	30. Name and address of person wito completed cause of death (Item 23a) (Type, Print)	
Sta Registr	31. Date filed (Month, Day, Year) 32. Registrar's Signature	mbig MD 21044

		ERFor Unpend Item State Registrar 1. Decedent's Name (First, Middle,								2. Date of De Month		Year	3. Time of Death
Physicia /Medic		Tori Ghiglieri								JAN.			0806 A
Examin		4a. Facility Name (If not institution,						r Location	of Death			unty of Deeth	
		LAUREL REGIONAL					UREL	If Under	Od Hee				SEORGES
Funeral Director		5. Social Security Number Infant	5. Sex 1 □ M 2 X F	7. Age (In yrs	. last birthday; Yrs.	Months 3	Days 2	Hours	Min.	8. Date of Bi (Month, Di 10/10	7003	9. Birth Cou	npla <i>ce (State or Forei</i> untry) 1D
3		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limit
Department of Health and Mental Hygiene. Important: to items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner traus by Indifficial at ODEs.	ŏ												1 □ Yes 2 🔀
288-	Director	MD Prince	Georges		Laure	10f. Zip	Code				10g. Citizer	n of What Cou	untry?
o and		MINUSHE WAS	D					2070	٦0			USA	,
11.00	Funeral	11704 Montague	12. Was Dec	edent Ever in t	J.S. 13.	Was Deced	dent of H			ecify Yes or No Rican, etc.)	0- 14.	Race - Amer	
e e	F	1 Never Married 2 Marrie	Armed Fo	2 15 No	-					Hican, etc.)		Black, White	etc.
1	þ	3 Widowed 4 Divorced	If Yes, G Year or D	Dates:		1 🗆 Yes	2 (25LNO	Specify:			Sp	pecify:	White
哥	Completed	15. Decedent's (Specify only highest)	16a. Dece	dent's Usua kind of wo DO NOT us	I Occup	ation during mos	t of work	ing	16b. Kind	of Business/li	ndustry
a Mes	현	Elementary/Secondary (0-12)	T	(1-4or 5+)	life.			1)					
₽	S	Infant				Infa	nt	10 Mark	ada Na as	e (First, Middle	Maidan Su	Infant	<u> </u>
0.0	Be	17. Father's Name (First, Middle, L.	,					18. Moth		•		•	
natic	٩	Michael Ghiglie 19a. Informant's Name/Relationshi			10h Maili	Add:	/Street	a and Alexandra		ohanie			in Code)
traur						•				I Austa Numb			ip Code)
ther	ŀ	Stephanie Sweet 20a. Method of Disposition	ser/Moth		Place of Disp	4 Mon	ne of			Laurel		tion - City or T	Town, Stata
0 0		1 ⊠Burial 2 □ Cremation		State	cemetery, cre	matory or o	ther plac	1		. / /		•	
nju.	}	* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral-Service L		Lo	rraine							cimore,	
any ir		21. Signature of Company Company	COLISOO .		St	erlin	g As	hton	Sch	wab Fun	eral H	Home,	Inc.
-15		23a. Part1 Enter the disease, or o shock, or heart failure. List o	complications that	caused the dea						Baltim or respiratory a		M 2124	Approximate
		shook, or heart failure. List o	nly one cause on	each line.									Interval Between Onset and Death
ician dical		disease or condition resulting in death)		Or as a conse	guence of):								
iner				ERLAY	quonos on.								
	er	Sequentially list conditions, if any, leading to immediate	D	(or as a conse	quence of):								
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C										
rial-t	EX	resulting in death) Last	Due to	(or as a conse	quence of):								
he burial-transit	Icai		d										
9 25	by Physician/Med	fF FEMALE:										1	
or us	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregr birth 2 ☐ Fet	al death 3	Ectopic pr					230	I. Date of delive Month	very Day Year
detached for use as th	sic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Preg 9☐Unkr	nant at time of	death 5	Other (sp	өспу)						
detac	P.	Part II. Other significant condition	s contributing to c	death but not re	sulting in the u	ınderivina c	ause giv	en in Part I		23e. Did	tobacco use	contribute to	the cause of death?
8	by by	, <u></u>				,,,,,,	3				Yes 2 1		bably 4 Unknow
hour	etec										/_		
4	Completed									24a. Was	psy prmed?	prior to co teath?	opsy findings availab ompletion of cause of
irector, page 2 s										1 Doyes	2 No	1) SDYes	2 No
920	Be	25. Was case referred to medical examiner?	Hospital:		V		Oth			(Check only			
rald	. 70	1 X Yes 2 □ No 27. Manner of Death	ODe Date	of Injury	XER/Outpatie	f 2	8c Inun	4 INC		me 5 Res 28d Describe			ify)
fune	tio	1 □Naturaf 5 □ Pending 2 🖁 Accident investiga	FOUR	th, Day Year)	FOUND 7:45	APPRO) Worl	k? Yes 2. X		ASPHYXI			ERT.AY
y the	Certification:	3 ☐ Suicide 6 ☐ Could no	1/2.4	/04 e of Injury - At I ling, etc. (Spec		reet, factory	, office						ndryague i
dint	erti	4 ☐ Homicide determin		ling, etc. (<i>Spec</i> IDENCE	erfy)					LAUREL,	wn, State) .	L1704 I [.AN])	AUNTAGUE).
completely filled in by the funeral director, page		29a. Certifier (Check only 2 Certifying 2 Medical E	Physician: To the taminer: On the t	e best of my kn	nowledge, deat	h occurred	at the tin	ne, date ar	d place,	and due to the	cause(s) an	d manner as :	stated.
plete	Medical	one)	and mar	per stated.									```
ГОО	2	29b. Signature and title of certifier	-//	/,		290		• number •M•E			JAN.	igned (Month, 25 ,	
			AV.	ms			0.0	•11•L			22114.		
		30. Name and address of person	no completed can										
		11/1/1/1/1	// / 11/// /	A / I	111 -	^1		_ n	+	re, Mai	~~~	21201	

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** GRAVES 915 PM HARLIE JANUAR 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner A BALTIMURE MD JUHNS HOPKINS HUSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign 5. Social Security Number **Funeral** 10M 2□F 3.32.625 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural, or items 23a or 28a-f show other traumatic event, the Madical Exertiner must be notified at 1 ☐ Yes 2 No Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Tircle Unit Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, elc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 Ø No Baltimore, Maryland 21215-0036 Specify. Specify: If Yes, Give Year or Dates: BIACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedenl's Education (Specify only highest grade completed) Co**vege** (1-4or 5+) f Health and Mental Hygiene. 222 Hilehem 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I To Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lesville, mo 21208 WiFe Stone hence 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) /moniom U/anec Valley Green Funeral Services 21. Signalure of Funeral Service Licenses 22. Name and Address of Facility Value Randalistown aucs Keene 23a. Part 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition **Physician** PHARYNGEAL HEMOPTYSIS trown DAYS SEVEN resulting in death) /Medical Due to (or as a consequence of): Examiner OPD ONE YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit RESPIRATORY FAILURE DAY UNE HUPERCAPNIC that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, physician Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Year ŏ Month 4 Pregnant at time of death 5 Other (specify) been signed by the sahould be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 TYes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 2 1 No 1 Yes 2 🗱 No 1 TYes of Vital Physician: completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🔛 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? Division 1 Matural 5 Pending 1 □ Yes 2 □ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES -JANUARY 29, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h 600 N. Woife St, Baltimore MD 21287 Hopkins Hospital Munsell The Johns Melissa 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

1 - Steb Registrar	State of	Maryland / Dep <i>Ce</i>	artment of He	ealth and M	lental Hygie	re Legible. ^{ene} 2004	02798
/Medical	st, Middle, Last) MMY	GARLAND		, odin	2. Dele of Death Month	Day Year	3. Time of Death
Funeral 5. Social Security Number	natitution give street and num E GROVE ROAD		4b. City, Town, or I BROOKLY	N PARK	FEBRUAR	Y 01 2004 4c. County of Death ANNE ARUN	DEL CO
Director 223-46-6358	120 M 2□ F	'. Age (In yrs. (ast birthdey) 66 Yrs.	# Under 1 Year Months Days	li Under 24 Hrs. Hours Min.	8 Date of Birth (Month, Day, Y) February	ear) 9. Births	blace (State or Foreign http) Vinginia
Maryland 100. Street and Number	Anne Arundel	10c. City, Town or Le Baltimo		****		1	Od. Inside City Limits
Maryland 10a. State Maryland 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number 10b. Street and Number	Ol Belle Grove	ink.		21225	l l	Citizen of What Cour JSA	
12.15-0036 11. Marital Status 11. Marital Status 12.0036 13. Widowed 4 (X) 15. C. (Soecify on Elementary) Secondary 15. C. (Soecify on Elementary) Secondary	Married I X Yes 2	- 1/	Was Decedent of His I Yes, specify Cuban.	panic Origin? (Spe Mexican, Pueno f Specify;	City Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: 1.	●tc.
Cooping of the second and the second	ecedent's Education y highest grade completed) (0-12) College (1-4	lor 5+)	dent's Usual Occupati kind of work dorie du DO NOT usa ratired)	ion ring most of workin	•	b. Kind of Business/Inc	•
		Carc	enter	8. Mother's Name Venus	(First, Middle, Max Darnel 1	Constructi	on
	(Daughter)	19b. Mariin 5601	e Address (Straet and Belle Gr	d Number of Rural	Boule Number Ci	ty or Town, Stale, Zip e Md	Code) 21225
1 🖾 Burial 2 🗆 Crem	nation 3 ⊟Removal from St. ther <i>(Specity)</i>	20b. Place of Disposition Cedar Hi	sition (Name of place)	O	ite 20c	Location - City or To	wn, State
_ 8526	envee Licensee Kevin	E Ecker 22 Mo	Cully-Pol	or Facility yniak Fur	neral Hom	ie, P.A.	225-1856
Physician /Micdical Examiner Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition of any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last OSCIONATION OF THE PROPERTY OF THE	b. Due to (or	as a consequence of):	The mode of dying, 1	such as cardiac of	respiratory arrest,		Approximate Interval Between Onder and Death Onder Son Control
W 20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	? 1∟Live birth 4⊟Pregnant 9⊡ Unknown	2 ☐ Fetat déath 3 ☐ E al time of death 5 ☐	Estopic pregnancy Other (specity)		- This	23d. Date of deliver	y Day Year
COrds be been along the requirement of the property of the pro	tiseb or polludininas anoidbac	bul not resulting in the und	derlying cause given i	n Pan I.	-	o use contribute to the	e cause of death?
	Hospital: [Inpa		3C DOs 9mer.	3. Place of Death (24a. Was an autopsy performed 1 Yes 2 (Check only fine)	24b. Were autop prior to comdeath?	ey findings available pletion of cause of
Olvision Jerral Agental Agen	Pending 28a. Date of In (Month, Date of In (Month, Date of In (Month, Date of In (Month), Date of In (Mont		28c. Injury at Work? M I Yes	4 Nursing Home 28 2 No	d. Describe how in	and Number of Burst	
Se a la la la la la la la la la la la la l	rtifying Physician: To the besidical Examiner: On the basis and manner:	it of my knowledge, death of examination and/or investated.	ocurred at the time, o	date and place, an			ited. the cause(s)
otil the	endiur S	3	29c. Ucense nu			Date signed (Month, D	
State 31. Date titled (Month, Day,	OT V WENT	death (Itom 23a) (Type, Pr	Hendre	5+	Balt	more Ma	2/22
D - 1	0 3 2064	aux de		· · · · · · · · · · · · · · · · · · ·		,,,	

alter Go	OIC	1 - State Registrar		of Marylar	nd / Depa	artment o	f Health of Deatl	and M		Reg. No.	200	
Physic	an	1. Decedent's Name (First, Middle Walter D.	Gobis						2. Date of De Month Februe	Day	Yes 1 2004	
/Medi Examir		4a. Facility Name (If not institution	give street and nu	ımber)		4b. City, Tow	m, or Location	of Death	rebru		County of D	
		8 Charles Pla		North		Balti				N/		
Funeral Director		5. Social Security Number 139-03-6179	6. Sex 1 □ M 2 □ F	7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Y Months Da	ear If Unde	Min.	8. Date of Bir (Month, Da FEB 20	yeer)	9. E	Birthplace (State or Foreigi Country) LLINOIS
/land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
Many B-f sh	tor	Maryland N/A		Ва	ltimor	е						1 XYes 2 No
or 28	Directo	10e. Street and Number	#0505			10f. Zip Co				-	zen of What	Country?
eath v	eral	8 Charles Plaz		North I		21201 Was Decedent		rigin? (Spe	ocify Yes or No	USA	14 Race - A	mencan Indian,
after d	Funeral	1 Marital Status 1 Mover Married 2 Marri	Armed F	orces?	342-	If Yes, specify	Cuban, Mexic	an, Puerto	Rican, etc.)		Black, W	hite, etc.
ours a	d by	3 Widowed 4 Divorced	If Yes, G Year or D	Dates: 19	945	1 □ Yes 21√2	No Specif	y: 			Specify:	White
n 72 h natu	Completed	15. Decedent (Specify only highes	's Education t grade completed,)	(Give	dent's Usual Oo kind of work do DO NOT use re	one durina mo	st of worki	ng	16b. Kir	nd of Busine	ss/industry
withii iene. r than	omp	Elementary/Secondary (0-12)	College ((1-4or 5+)		ercial A				Adv	ertisi	ng Agency
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-1 show aumaite event, the Medical Evan for man be recitified at	Be C	17. Father's Name (First, Middle,					18. Mot	her's Name	(First, Middle.	, Maiden	Sumame)	
ould b Menta	Tof	Ladislao Gauba							tuliut			
12 sh h and 7 Is m traum		19a. Informant's Name/Relationsh Thomas Unitis/				ng Address <i>(St</i> Cedar					Town, State	e, <i>Zip Code)</i> 21048
tem 2		20a. Method of Disposition	nepnew	20b. I		osition (Name of matory or other			ate			or Town, State
Pages nent of nt: If I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Si	3 □Removal from ecify)			ematory		2-2-	-04	Bal	timore	e, MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itams 23a or 28a-1 show eny figury or other traumatic event, the Medical Examination at once.		21. Signature of Funer Loervice	Et. Vin	hik	22	Cremati 299 Fre	ddress of Fac.	ciety	of MD,	Inc	re, MD	21228
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea							LC, LIL	Approximate Interval Between
Pnysician /Medical Examiner	J.	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to	rioscler (or as a consec	quence of):	ardiova	scular	Dise	ease			Onset and Death
uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.)		(01 40 4 001000	(40/100 01):							
te be executed ysician and e burial-transit	cal Exa	resulting in death) Last		(or as a consec	quence of):							
ifficate g phy: as the			d									
ician: The law requires that the death certificate be executed certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	atcome of pregn birth 2 Teta nant at time of conown	al death 3]Ectopic pregn] Other (specif				2	3d. Date of o	delivery Day Year
w requires that been signed b should be deta	by	Part II. Other significent condition	ns contributing to o	death but not res	sulting in the u	nderlying cause	given in Parl	:1.		obacco us Yes 2[to the cause of death? Probably 4 □Unknown
The law reate has bee	Completed				· · · · · · · · · · · · · · · · · · ·						24b. Were prior t death 1 🗌 Y	
Physician: Trips certificated director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othor		(Check only o			
Phys rat di	To To	1 X Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time o	f 28c.	4 □ r Injury at		ne 5 🗌 Resid 28d. Describe I			oecify) at scene
Attending Physician: The education of the func	Certification:	1 □Xstural 5 □ Pending 2 □ Accident investig 3 □ Suicide 6 □ Could r	ation ot be	oth, Day Year) e of Injury - At h	Injury	М	Work? 1 ☐ Yes 2 ☐]No				Rural Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the the		4 Homicide determ	build	ling, etc. (Speci	fy)				City or Tov	wn, State)		
e Hos 24 hc e Fun letely l	edical	29a. Certifier 1☐ Certifyin (Check only 2 ★Medicel I	g Physician: To th Exeminer: On the l and mar	e best of my kno pasis of examina nner stated.	ation and/or in	vestigation, in r	ny opinion, de	ath occurre	ed at the time,	date and	and manner place, and d	ue to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier	11 V.			29c. Lio OCME	ense number					onth, Day, Year) 2 2004
R,		30. Name and address of person	640			111	Penn S	treet	, Balt	imore	e, Mar	yland 21201
Sta		31. Date filed (Month, Day, Year)	F/2 /1 2 32	Registrar's Sig	ture	R.	•				-	
Regist	rar		ED 0 0 60	THE POLE	Mars.	15	and i				~	

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Months 1- State Registrar		ene 2 0 0 L	02800
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	1	3. Time of Death
	Physici		Charles W. Glasgow	JAN 3	Day Yeer 30, 2004	3:20 p M
	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dee	
			Manor Care of Silver Spring Silver Spring		Montgom	erv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1f Under 1 Year 1f Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign puntry) DISTICT
	Director		579-12-7841 22 m 22 n 23 n	OCT 25,	1017	Columbia
	pun 🛊		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	•ho	5				1 ☐ Yes 2 No
	286-1	ect	Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	ountry?
	with	Funeral Directo	606 Sligo Avenue 20910		USA	,
	heath	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Am	
0	riter	핕	Armed Forces? If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, Whi	
3	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or fleme 23s or 28e-f show event, The Medical Examinar must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:		Specify:	White
ה ה	72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	1	6b. Kind of Business	/Industry
7	ithin	nple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)			
V	ed w ygier ygier ygier th	Cor	5 Busiliess Owner		Seafood	Market
and	be fill	Be	17. Father's Name (First, Middle, Last) Augustus Glasgow Joseph			
2	d Mer narke	10		ine Sche		7:- O- d-)
<u> </u>	d 2 st th and 7 ie r		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Cathography P. Classocytyrife 606 Cliss Array City		1000 600000	100
a,	1 an Heall em 2	-	20a. Method of Disposition 20b. Place of Disposition (Name of		oc. Location - City or	
٥	ages int of t: # if		Comparing 3 Demoyal from State Cemetery, crematory or other place)	1/04	Baltimore	MD
aitimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or iteme 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.					
מ	Depar Impo any ic		21. Signature of Fundamental Service Licensed Control Cremation Society Dawn F. McDonald 299 Frederick Roar	of Mary	land, Inc	
	3/4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final			Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	4		Month
	Examiner		Sequentially list conditions			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Due to (or as a consequence of):			
	and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8/00,	be ex cian a		Due to (or as a consequence of):			
Ö	death certificate be executed e attending physician and od for use as the burial-transit	dlcal	d	· -		
XO	wrequires that the death certifit been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	liven
Ď	atter f for u	clan	in the past 12 months?		Month	Day Year
j.	the d	lys	1 Yes 2 No 9 Unknown 9 Unknown			
	s that ned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute t	the cause of death?
Hecords	requires that the leen signed by th hould be detache			1 ☐ Yes	s 2□No 3□P	robably 4 Unknown
ပ္သ	lawre as bee	Completed		24a. Was an		utopsy findings available
	sicien: The law certificate has b irector, page 2 s	E		autopsy perform 1 Yes 2	ed? death?	completion of cause of : 2□ No
Vitai	ien: rtifica stor. p	Bec	25. Was case referred to medical 26. Place of Death			
	Physicien: r this certific ral director,	To	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Hom	ne 5 🗆 Resider	nce 6 Other (Spe	cify)
Ö	ng Pi		1 Natural 5 Pending (Month, Day Year) Injury Work?	8d. Describe hov	w injury occurred	
200	eath. or: A	catl	2 Accident investigation M 1 Yes 2 No			
DIVISION	or Att	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
נ	pitel		20g Codifier 199 Cartifying Dhydisian: To the heat of my knowledge death segured at the time date and place a	ad dua to the con-		
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the date and death occurred at the date and death occurred at the time, date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date and death occurred at the date	d at the time, dat	use(s) and manner a te and place, and du	stated. to the cause(s)
	ro the vithin o the omple	Me		29	d. Date signed (Mont	
,	- s + ō		D43260	ひ ブ	anuary	31,2004
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		(,
	1.		13952 Baltingore Ave Laurel Maryland	2070	7	
	Sta		31. Date filed (Month, Day, Year) 12. Registrar's Signature			
	Registr	ar	LED 0 0			

			1- For Amend Item#1,	eState of Marylar	d, Departmer Certifica	nt of Health and te of Death		giene 2004	02801
	Dhyaisi		1. Decedent's Name (First, Middle, Las	CEOTIS C	ASKIN .		2. Date of Dear Month	th Day Year	3. Time of Death
1	Physici /Medio		CEOTIS	110 61	45KIN		01	30 2 Year	10:47 PM
and .	Examir	er	4a. Facility Name (If not institution, give	11		, Town, or Location of Deal	h	4c. County of Death	1/2
			5. Social Security Number 6. Se	RS HOS P17 x 7. Age (In yrs,	A Section .	r 1 Year if Under 24 Hrs	8. Date of Birth	/V	place (State or Foreign
	Funeral Director			ÂM 2□F	7 Yrs. Months			, Year) Cou	ntry)
	ס		Usual Residence of Decedent				047.00	977.00	THENTOCTOR
	arylar show	_	10a. State 10b. County	10c. Ci	ity, Town or Location	0	0		10d. Inside City Limits 1 X Yes 2 □ No
	8e-f	ecto	MAKYLAND 1	JA		GALTIMO	Y		
	with ti	급	10e. Street and Number	-0.000.00	- A. / 10t. Zi	p Code	22	Og/Citizen of What Cou	
	eath Ps 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was Dece	edent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ameri	
(0	r Ren	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo		edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	etc.
5-0036	72 hours after death with the Maryland neturel', or items 23e or 28e-f show disal Examinar must be notified at	ģ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 Tes	2/10 No Specify:	134	Specify: B2	-ACK
	72 h netu	Completed	15. Decedent's Ed (Specify only highest grad	ication le completed)	16a. Decedent's Usu (Give kind of w	al Occupation ork done during most of wo use retired) .	rking	16b. Kind of Business/Ir	ndustry
121	filed within Hygiene. Ither then "	du	Elementary/Secondary (0-12) 8 HGRADE	College (1-4or 5+)		LIFT DRI		TERMINI	21 (000
d 2	filed within Hygiene. other then ent, the M	Be Co	17. Father's Name (First, Middle, Last)		1021		me (First, Middle, I		1200711
<u>lan</u>	ould be Mental sirked o	To B	SAM	6	FASKINS	SAR	AH	THE	MAS
Mary	2 should and Men Is marke eumetic	Γ,	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addres	s (Street and Number or R	ural Route Number	, City or Town, State, Zi	o Code)
	and 2 ealth m 27 her tr		SARAH GASKINS	(MOTHER	12510		IOUNT A	E, BALD, 1	40,21223
ore	ges 1 t of H If itel or otl		20a. Method of Disposition 1/2 Burial 2 ☐ Cremation 3 ☐		Place of Disposition (Na cemetery, crematory or	other place)		20c. Location - City or T	1
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show my injury or other treumetic event, the Medical Examination at the profiled at ance.		'4 ☐Donation 5 ☐ Other (Specify		ING MEM.	4 4 4		WOODLAG	
Ba	permit. Departr Importe eny Inju		21. Signature of Funeral Service Licens	N. Willia	mo 505	nd Address of Facility BR	VAVE, &	FUNERA	D. 21217
	1 1 1 1 1		23a. Part1. Enter the disease, or comp	lications that caused the dea	th. Do not enter the mo	7 01 - 1		est,	Approximate
4	Pnysician	y III	shock, or heart failure. List only of Immediate Cause (Final disease or condition	ORDIO	Dulma	lary A	OP =C	7	Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as a conse	1	1819	VC 2 3	/	-
	Examiner	L	Secuentially list conditions	SEPT	ICEN	nboli	-		Value 2. Pr
	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):	Fodge	10017	7 7	
	xecut and al-trar	Examin	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):	271000	ARDIT	13	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	calE		BRAL	1 Posit	IVE BAC	TERET	MIA	
9	tificate ig phy as the	Physician/Medical		V					
Box	th cer tendir r use	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		pregnancy		23d. Date of deliv	,
_	e dea the at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o				Month	Day Year
P.0	res that the death certific igned by the attending p be detached for use as i	Phy	Part II. Other significant conditions of	ntributing to death but not res	sulting in the underlying	cause given in Part I	23e. Did tot	bacco use contribute to t	he cause of death?
ds,	signe d be	d by	Diabetic	KetoACIT	20515	3 /-2-1 11/-2-11	1 □ Ye		1
Ö	w requir been si should	ete	Totalonos	S DRUG	USE		24a, Wasa	n 24h Were autr	nosy findings available
Re	ricien: The lav certificate has rector, page 2	Completed	A N/Eil	1	930		autops perform	ged) death?	opsy findings available impletion of cause of
ta	en: T	BeC	25. Was case referred to medical	<i>T</i>		26. Place of De	1 ☐ Yes 2 ath (Check only on	2 No 1 ☐ Yes	3 No
Ξ	Physicien: this certification, ral director, ra	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 D	Othor		ance 6 ☐Other (Speci	(y)
0	ding Ph h. After th funeral	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	ow injury occurred	
sio	tendi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No	0011 (0		
Division of Vital Records,	I or Attendi after death. Director: A I in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factor ify)	y, office	City or Town	reet and Number or Run n, State)	al Route Number,
	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the funer		29a. Certifier Certifying Phy	rsicien: To the best of my know	owledge, death occurred	at the time, date and place	e, and due to the ca	ause(s) and manner as s	stated.
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h. completely filled in by the funeral director, page	Medical		iner: On the basis of examina and manner stated.					
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			c. License number		9d. Date signed (Month,	Day, Year)
			J. G. Ham. / ton	MP Stuff	Dry Sicism	1082	9/	01-30	-2004
	(30. Name and address of person who o	ompleted cause of death (ite	m 23a) (Type, Print)	DO82 St. Baltin	ME ME	1 2 12 2	3
	-04		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature of a sure	11.1001111	witt,	4,6100	_
	Sta Regist		FFR 0 3 ZUU4	gentlement of the second	The same of the sa				

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 02802 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lynn Ann Garcia Jan. 2004 12:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 9 Clipping Tree Lane Hunt Valley
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 218-36-7119 63 12 1941 MD Usual Residence of Decedent worde 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD **Baltimore** Hunt Valley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 9 Clipping Tree Lane 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 7 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 3 Registered Nurse Health Care s 1 and 2 should be filed vil Health and Mental Hygie Item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Hennaut ပ Mary O'Shea 19a. Informant's Name/Relationship (Type, Print) (husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Clipping Tree Lane, Hunt Valley, MD 21030 Dionisio Garcia, Jr., M.D. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If ite any injury or ot 2/4/04 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21093 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Ser Michael J. Flagle 23a. Part Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 - Other (specify) 4 Pregnant at time of death signed by the a P.O. I ☐Yes 250No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 Records, 3 Probably 4 □Unknown 2 No Completed D990 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 ☐ Yo Other: 4 Nursing Home seidence 6 Other (Specify) 2 2 ER/Outpatient 3□ DOA ō this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Lescribe how injury occurred Certification: After Division Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funaral Director: the 6 Could not be determined 3 ☐ Suicide in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō pellil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medical completely the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 20649 w 30. Name a address of person completed cause of death (Item 23a) (Type, Print) Bldg. 9 John Bowie, M.D. GBMC Suite 4902, 6701 N. Chas. St., Towson, MD 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 34

DHMH 17 Rev 1/2001

Registrar

FFB 0

*			For State Registrar	State of Maryla		artment of H tificate of I			giene Reg. No. 20 (02803
f	Physici		1. Decedent's Name (First, Middle, Las		_			2. Date of De Month JANUF	Day Y	3. Time of Death
	/Medio Examir		Maria Cristi 4a. Facility Name (If not institution, give Saint Joseph	e street and number)	enter	4b. City, Town, or		th ISON	4c. County of	
	Funeral Director		5. Social Security Number 6. S 219-60-5101	ex 7. Age (In y.	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ly. Year) ry 28, 19	Birthplace (State or Foreign Country) MD
	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "naturel", or items 23e or 28e-f show event. Its Medical Evandrer must be rediffied at	ai Director	Usual Residence of Decedent	ore	City, Town or Lo	10f. Zip Code	6		10g. Citizen of Wha	10d. Inside City Limits 1 □ Yes 2 □ No at Country? I States
-0036	hours after des	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed	12. Was Decedent Ever in Armed Forces? 1		Was Decedent of H f Yes, specify Cuba □ Wes 2□ No dent's Usual Occupa	Specify: Me		14. Race Black, Specify:	American Indian, White, etc. White ess/Industry
9500-G1Z1Z bi	filed within 72 Hygiene. other then "natent, I've Medici	e Completed	(Specify only highest gra Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	(Give	kind of work done of NOT use retired	during most of we	-		al Law
Maryland	nd 2 should be lith and Mental 27 Is marked c r traumatic eve	ToB	Roberto I. Guti 19a. Informant's Name/Relationship (Roberto I. Gutie	Type, Print)		g Address (Street a	and Number or F		hettle er, City or Town, Sta D. 21286	
saitimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 Is marked sny injury or other traumatic evonce.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specifications)	Removal from State	illtop S	sition (Name of natory or other place VC. Corp. Name and Address	. 02/	Date (02/2004		Maryland
g	permi Depa Impo sny is		23a. Part 1. Erner the disease, or comshock, or heart failure. List only	S.D. Coste	er	1050 York	k Road	Towson,	Maryland	ral Home, Inc. 21204 Approximate Interval Between
	Physician and // Medical Examiner physician and physician and physician site physician site physician site physician site physician site physician site physician site site site site site site site site	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consumption of the consumption o	sequence of): CARD I sequence of):			BRILLAT	ION	Onset and Death
.O. BOX 68/6U	The law requires that the death certificate be ite has been signed by the attending physicia age 2 should be detached for use as the burn	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preduction of the second of the se	etal death 3 [Ectopic pregnancy			23d. Date o Month	f delivery Day Year
Records, P	requires that been signed k	þ	Part II. Other significant conditions of Multiple Scleros	-	· ·	nderlying cause give	en in Part I.	1)X	/es 2□No 3[te to the cause of death? Probably 4 Unknown
итал жес	The lay ate has page 2	se Completed	25. Was case referred to medical				26. Place of De	24a. Was autop performance 1 Yes	osy prio rmed? dea 2 No 1 □	e autopsy findings available r to completion of cause of h? Yes 2 No
ō	Phys this ral di	ation; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. te of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 □ Nursing	_	dence 6 Other (Specify)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	l Certification;	3 Suicide 6 Could not be determined		ecify)		and data and place	City or Tou	vn, State)	or Rural Route Number,
	To the Hos within 24 hd To the Fun completely	Medical	(Check only one) 2 Medical Examone) 29b. Signature and title of certifier	niner: On the basis of exam and manner stated.	ination and/or inv	vestigation, in my op	oinion, death occ	urred at the time,	date and place, and 29d. Date signed (A	due to the cause(s)
	10		Mach A . Go 30. Name and address of person who	completed cause of death (I	item 23a) (Type,		6639	1	1/30/5	
	Sta Registi	-	MARK GOLDSTEI 31. Date filed (Month, Day, Year)	32. Registr's Sig		ER DRIV	E TOWS	IN, MAR	YLAND 21	204

			1 - For State Registrar	State of Marylar	nd / Depa			lental Hyg	iene	0 4 (2804
			1. Decedent's Name (First, Middle, Las	et)				2. Date of Deat			Time of Death
	Physici /Medio Examir	cal	Russell L. Hi 4a. Fecility Name (If not institution, give			4b. City, Town,	or Location of Death	Month January	29 20 4c. County		:00 A. M
			14 Giddings Av	e.		Seve	rna Park		Anne	Arunde	1
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,			(Stete or Foreign
¥	Director		215-09-8507	№ 2□F 85	Yrs.	Months Bayo	, riodio iniai.	02/15/1	918	MD	
	and *		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation				104 4	nside City Limits
	Aaryl sho	5			•						Yes 2 No
	289-1	Director	MD Anne Ar	undel S	Severna						
	with		Too. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Country?	
	eath	Funeral	14 Giddings Ave.	12. Was Decedent Ever in U	C 12.1	Man Decedes of	21146		USA		
	fterr d	Ë	1 Never Married 2 Married	Amped Forces? 1 (A) Yes 2 □ No		Yes, specify Cut	Hispanic Origin? (Spo pan, Mexican, Puerto	Rican, etc.)		- American In k, White, etc.	dian,
38	irs af	by	3 X Widowed 4 □ Divorced	If Yes, Give		I□Yes 2⊠No	Specify:		Specify		•
ŏ	2 hou	ed	15. Decedent's Ed	MMTI	16a, Deced	lent's Usual Occu	pation		6b. Kind of Bu		ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Mudical Examinar must be notified at	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	kind of work done OO NOT use retire	during most of work	ing	oc. King of bu	anie a anii Quati)	
2	d with	E	12	College (1-4or 5+)	In	spector			Machine	Tooli	nσ
	othe	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name				6
<u>a</u>	lid by	To B	William J. Hild				Minnie	Schroede	r		
Maryland	short and A	Гъ.	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street	t and Number or Rura			State, Zip Code	e)
	alth alth 27 fig.		Vernon Hild/Nepher	W		iverside			na. MD		
ē	of He item		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of natory or other pla			0c. Location (State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Mudical Exprining must be notified at ADRE.		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	TOTAL TOTAL STATE			ery 01/31	/2004	Do1++	MD	
ä	mit.	4	21. Signature of Funeral Service Licens		22	. Name and Addre	ess of Facility	/ 2004	Baltimo	re, MD	
m	Depa Depa Impo any in	10	1) Kenst ()	-Also	St 73	erling A 6 Edmond	ess of Facility Shton Scho Son Ave.	wab Fune	ral Hom	e, Inc	•
þ			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	n. Do not ente	er the mode of dyi	ng, such as cardiac c	r respiratory arre	st,	Appr	oximate
	Physician		Immediate Cause (Final disease or condition	Mal	- 1- ·	D	. (.)	2		Onse	val Between et and Death
	/Medical		resulting in death)	a. Due to (or as a consequence	uence of):	FREC	ital (iance	_V	52	jear S
E	Examiner			b							
	n ==	ner	if any, leading to immediate	Due to (or as a consequ	uence of):						
	nd ransi	Examiner	that initiated events	c							
760,	te be executed ysician and ie burial-transit	Ä	resulting in death) Last	Due to (or as a consequ	ience of):						
876		lcal		d							
<u> </u>	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as the	Physician/Med	IF FEMALE:								
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnanc	y		1	of delivery	
	e de the a	sici	1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown	eath 5	Other (specify) _			Mont	th Day	Year
<u>Р</u>	that the de led by the a detached f	Phy		asainsia - s - d - sh fi . s - s -	Internal Control						
Ś.	res tha	þ	Part II. Other significant conditions co	ntributing to death but not rest	illing in the un	derlying cause giv	en in Part I.		cco use contrib		
oro	w require	ted						1 Tes	2 No 3	3 Probably	4 Unknown
Records,	law nasb e 2 sl	Completed						24a. Was an autopsy	24b. W	ere autopsy fir ior to completio	idings available
		ပ္ပ						perform	ed? de	ath? □Yes 2□ N	
Viita	ysicien: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one			
0	hysi this c	2	1 162 5 140		ER/Outpatient	3□ DOA Oth	er: 4 Nursing Hon	ne 5 Residen	ce 6 Other	(Specify)	
Ē	ing P	on	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		8d. Describe how	injury occurre	d	
S	tend leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division	or Al	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	2	8f. Location (Stre City or Town,	et and Numbei State)	or Rural Rout	e Number,
	pitaf ours a erel (20a Cartilias		1.4.						
	or the Hospital or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of my knowner: On the basis of examinat	viedge, death ion and/or inve	occurred at the tirestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	se(s) and mani e and place, an	ner as stated. Id due to the ca	ause(s)
	To the within 2. To the complet	Med	29b. Signature and the of certifier.	and manner stated.		29c. Licens			I. Date signed		
	⊢ ≯ ⊢ ŏ		* Fullet	O IAD			354	290	/ n /		,
	(8)		20. Name and address of	malated or the at 1 in the	00-1 /** -		/ 227	1	1001	2004	•
	1		30. Name and address of person who co	ST AGNES	23a) (Type, P	CATO	NAVE .	BAIT	un o	1/22	9
	Stat	e	31. Date filed (Month, Day, Year)	32 Registrar's Signat				- rimir I	0	CIXX	1
K	Registra		FFB 0 3 200		ure	Carl.					

	4	For State Registrar	State of Maryla		ment of F			ene 2004	02805
Physicial		1. Decedent's Name (First, Middle, Las	ALL				2. Date of Death Month Januar	Day Year	3. Time of Death
/Medica Examine	100	4a. Facility Name (If not institution, give	street and number)	ta 15	b. City, Town, o	r Location of Death		/4c. County of Deat NA	h
Funeral Director		213-28-4417	7. Age (In yr 7. Age (In yr 7. Age (In yr		f Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 1-1-32	(ear) 9. Birt Co	hplace (State or Foreign untry)
aryland show		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Locati					10d. Inside City Limits XXXYes 2 □ No
death with the Maryland ms 23a or 28e-f show trists be rediffed at	Director	Md NA 10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	
	Funeral	1102 Druid Hill A	Ave. Apt. 70 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 No If Yes, Give	U.S. 13. Was	2120] s Decedent of Hes, specify Cuba	L lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - Ame Black, White Specify:	
72 hours	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grad	Year or Dates: ucation de completed)	16a. Deceden	t's Usual Occup	ation during most of work	ing 16	6b. Kind of Business/	
re, Maryland 21215-0 re, Maryland 21215-0 s 1 and 2 should be filed within 72 hr Health and Mental Hygiene. item 27 is marked other than "natur other treumatic event, the Maraical	Com	10th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Truck	Driver	18. Mother's Name	e (First, Middle, Ma	BG&E	1.0
Spen (Ce and Spen) (Ce and Mantal Hygians is marked other than aumatic event, than	To Be	Willie		Hall		Victoria	∄	Slate	
e, Mar 1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (7 Arthur Epps	Cousin	1010 H	E. North	h Ave., B	altimore,		02
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within popartment of Health and Mental Hygiene importent: If item 27 is marked other than any injury or other treumatic event, tha Ma		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	D. Place of Disposition Commetery, cremate of Tion (ory`or other plac	1-4-		oc. Location - City or Lansdowne,	
Baltimor permit. Pages Department of importent: If it		21. Signature of Funeral Service Licen			ame and Addre	•	Balt 1101 E.	imore, Md North Av	. 21202 e.
Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused the depne cause on each line.	· D.	he mode of dyir		or respiratory arres	rt,	Approximate Interval Between Onset and Death
876(sate be	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Anoxic Due to (or as a cons c. Cardac Due to (or as a cons d.	sequence of): Enceparence of): Arre	st	pathy			
Box 6 eath certiff attending for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 □Ec	etopic pregnancy ther (specify) _	y		23d. Date of del Month	ivery Day Year
cords, P.(ed by Pr	Part II. Other significent conditions of	ontributing to death but not r	resulting in the unde	erlying cause giv	en in Part I.		acco use contribute to : 2 □ No 3 □ Pr	/
II Record The law requested has been page 2 should	Completed						24a. Was an autopsy perform	prior to	topsy findings available completion of cause of 2 No
Vital F sicien: Th	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ☐ ER/Outpatient	3□ DOA Oth	NOT.	h (Check only one) ice 6 ⊟Other (Spe	260
Division of Vital Records, P.O. To the Hospital or Attending Physicien: The law requires that the dealing after dealing Physicien: The law requires that the dealing to the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	F 1	27. Mann r of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year,	28b. Time of	28c. Injur	4 🗆 Italianing inc	28d. Describe hov		5ny)
Divis	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, street ecify)	, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
Division To the Hospitel or Attended within 24 hours after death To the Funeral Director: completely filled in by the	Medical		ysician: To the best of my lander: On the basis of exam and manner stated.						
Torn	2	29b. Signature and title of certifier	Sul		29c. Licens	se number	29	d. Date signed (Mont.	h, Day, Year)
b	1	30. Name and address of person who	completed cause of death (I	Item 23a) (Type, Pri	nt)	nd Ben	eral 1	Hospita	1
Stat Registra		31. Date filed (Month, Day, Year) FFR 0.3 2004	J 32. Registrar's Sig	gnature	, Jan Hal	- 10	No. 10	7	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 29 Russell A. Hankey 2004 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 59 NO P 690 465 165 timol If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Months Hours 1**½** M 2□ F 91 Director 097-10-1435 NewYork Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or flems 23s or 28s4 show any Injury or other traumetic event, the Modical Examinar must be notified at MD Baltimore Middle River 1 ☐ Yes 2 ☑ No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 120 Compass Road 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: SpecifyWhite Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Purchase Agent 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown Levi Hankey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cliff Hankey / 903 Hillen Drive Millersville MD son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/2/04 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery Baltimore MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 described in the death of the mode of dying, such as cardiac or respiratory arrest, his one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ToF Hospital: Other: 1 Inpatient 2 ☐ ER/Outpatient 1 TYes 2 No 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27 Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Tyes 2 TNo 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter or To the Funeral Direct completely filled in by 4 | Homicide

Kussell, Hanker

edicai

29a. Certifier

(Check only one)

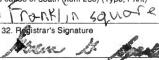
State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month

Vitto- rvinder Arora-9000

29b. Signature and title of certifier



Trank in

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Baltimore

29d. Date signed (Month, Day, Yeer)

		1 - For State Registrar	State of Mar	C	ertificate of	Death		g. No.	4 U280
Physicia	an	Decedent's Name (First, Middle, Las.	")				2. Date of Death Month	Day Year	3. Time of Death
/Medic		Margaret	D.	Hildi	itch		01 -	31-04	1:20 PM
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	th
		Franklin Square	Hospital Ce	nter	Bose	edale		baltime	re
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthd	Months Days		8. Date of Birth (Month, Day, September	Year) 9. Birt	hplace (State or Foreign
Director		210-20-0200	JW 5124 L	72 Yrs			September	3,1931 _M	
3		Usual Residence of Decedent 10a. State 10b. County	11	0c. City, Town o	r Location				10d. Inside City Limits
e how	ច	MD. Baltimore		Essex	Location				1 ☐ Yes 2X No
28a-1 notifie	ect	10e. Street and Number			100 7: 0 1		1.0		
ठ छ	급	1248 Bayside Road			10f. Zip Code 212:	21	10	g. Citizen of What Co USA	ountry?
Taust	Completed by Funeral Director		12 Was Dandost Fu	orio II C d					ware to diese
dical Examiner	Ě	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 No	er in U.Ş.	 Was Decedent of H If Yes, specify Cub 	an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
ZBZ	by F	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify: W	hite
dical Ex	ed	15. Decedent's Edu		16a De	cedent's Usual Occur	nation	14	6b. Kind of Business	Industry
454	oiet	(Specify only highest grad	le completed)	(G	ive kind of work done e. DO NOT use retire	during most of works	ing	ob. Kind of business	industry
The h	Шо	Elementary/Secondary (0-12) 11 years	College (1-4or 5+)		ephone Ope			ohne Hook	ins Hospital
umatic event, In	C	17. Father's Name (First, Middle, Last)		101	opriorie op		First, Middle, Ma		ins nospical
9	To Be	Norman Lee Hoffhei	ser Sr.			Margaret	Dorothy	Rothling	shoefer
mat	_	19a. Informant's Name/Relationship (T)		19b. M	ailing Address (Street				
important: If Item 27 le any injury or other trau once:		Carolyn Bossle	daughter	131	Bayside I			221	
otte		20a. Method of Disposition		20b. Place of Dis	sposition (Name of		Date or	Oc. Location - City or	Town, State
101		1 XBurial 2 Cremation 3 F	Removal from State		n Cemetery or other plants	1 - 0.0.2.0	ary		
injury or other traumatic event, the M		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerath Service Licens	1	CTESCIAN				arriottsv:	
any ir		V/ + Kmu		,00	Connelly I 7110 Solle	uneral Ho	ome Of Du	ndalk,P.A.	04000
3 0.		23a Part 1 Enter the disease of comp	ications that caused the	a death of act	7110 SOLLE	ers Point	Road, Du	ndalk, Md.	
Ship		23a. Parí 1. Enter the disease, ar compi shock, or heart failure. List only o	ne cause on each line.	9 30 1101	• O	ng, such as cardiac c	or respiratory arres	ι,	Approximate Interval Between Onset and Death
ician dical		Immediate Cause (Final disease or condition resulting in death)	a	H:	NOX1A				224-6
iner			Due to (or as a c		- E M	7.2 1		_	DAL
	-	Sequentially list conditions,	Due to (or as a c	DNG ES	TIVE TI	EART 1	ALLIN		
JSit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 43 4 0	onsequence ory.					
burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
anna I	calE								
t the			i						
for use as the burial-tran	Physician/Med	IF FEMALE:	3c. If yes, outcome of p	regnancy					
٠ ا	ian	in the past 12 months?	1 Live birth 2 [4 Pregnant at tim	Fetal death	3 Ectopic pregnancy	/		23d. Date of deli Month	very Day Year
be detached for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	e or death	5 Other (specify) _				
900	문	Part II. Other significant conditions con	ntributing to death but n	ot resulting in the	underlying cause giv	ren in Part I	23e Did toba	cco use contribute to	the cause of death?
p p	l by		•		, , , , , , , , , , , , , , , , , , , ,				obably 4 □Unknown
should	etec						:-	24410 0011	
	Completed						24a. Was an autopsy	24b. Were au prior to d	topsy findings available ompletion of cause of
	S						performe 1 ☐ Yes 2 €		2 □ No
	Be	25. Was case referred to medical examiner?				26. Place of Death	THE RESERVE TO THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TW		
wal director, page 2	2	1 1 162 2 - 140	lospital: 1 Inpatient	2 ER/Outpat	ient 3 DOA Oth	er: 4 Nursing Hor	me 5 Residenc	ce 6 □Other (Spec	ity)
funeral	9	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time	of 28c, Injur	y at k?	28d. Describe how	injury occurred	
the fi	cati	2 Accident investigation			M 1 🗆	Yes 2 □ No			
in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (3	- At home, farm, Specify)	street, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru. State)	ral Route Number,
	Se						,		
	-	29a. Certifier 1 Certifying Physical Check only 2 Medical Exemi	sician: To the best of m	ny knowledge, de	ath occurred at the tin	ne, date and place, a	and due to the caus	se(s) and manner as	stated.
ely filled in	Ca	one)	and manner stated	l.	resugation, in my o	piinon, death occurre	ou at the time, date	and place, and due	to the cause(s)
menery med in	ledical				29c, Licens	e number	29d	. Date signed (Month	Day Year)
	Medical	29b. Signature and title of certifier				-		02	,,,,
completely illied in	Medical	29b. Signature and title of certifier	197		D53	1306	JA	N 31 St.	2004
completely filled in	Medical	30. Name and address of person who co					JA	31 St	2004
	Medical	30. Name and address of person who co		123 2 K			JA	BALTO. M	2004

ORIGINAL

04-0 RJ	0774		1 - For Unpend Item #23	State of Ma a&b,27 per m	arylar e G82	nd / Depa 8 2/5/04	artmen tilicate	t of H	leaith and I	Mental H	ygien Reg. N	e 20	104	0280
	Physici /Medio		1. Decedent's Name (First, Middle, La Mary Karen	Hartung						2. Date of D Month Janu	Death D	ay	Year 2004	3. Time of Death
	Examir		4a. Fecility Name (If not institution, giv 5813 Meridale Av	enue			Ca	tons	Location of Death	h	4	c. County Ba	of Death Ltimo	ore
<u>)</u>	Funeral Director		5. Social Security Number 6. S 218-60-9180 1 Usual Residence of Decedent	ex 7. Ag □ M 2 TF	e (In yrs. 5.	3 Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D JAN 5	inth Day, Year , 19			place (State or Foreigntry) 12 And
	the Maryland	ector	10a. State 10b. County Maryland Baltimor 10e. Street and Number	·e		ty, Town or Lo tonsvil	lle							0d. Inside City Limits
	23a or	Funeral Directo	5813 Meridale Ro	ad			10f. Zip 212				US. C	itizen of V A	Vhat Cour	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Dryorced	12. Was Decedent Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1	Was Deced f Yes, spec 1 ☐ Yes 2		ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	10-		k, White,	ean Indian, etc. White
Baltimore, Maryland 21215-0036	within 72 ho lene. then "natur the Mudical	Completed	15. Decedent's E. (Specify only highest grave Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5	i+)		kind of wor DO NOT us	k done d e retired	ation during most of wor ntative	king		Smet.		ompany
yland 2	ould be filed with Mental Hygiene arked other the atic event, the	To Be Co	17. Father's Name (First, Middle, Last) James A. Hahn						18. Mother's Nam	atricia	e, Maide Gat	n Sumam ely	θ)	
e, Mar	1 and 2 sho Health and Iom 27 io m		19a. Informant's Name/Relationship (Patricia A. Carv 20a. Method of Disposition	• • • • • • • • • • • • • • • • • • • •	20b. F	1902	Norhu	ırst	Way Nor	_	aton	svil	le, M	
Iltimor	permit, Pages Department of I Important: If Its any injury or or ance.		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature of Purers) Service \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	<i>'</i>)		Place of Disposemetery, crent of Cathedr	al Cem	etery	7 1 - 3:	1-04	Ва	1timo	ore,	
Ba	permit. Departrimportri		George E. Ma 23a. Part 1. Enter the disease, or com shock, or heart failure. List only		4	3	lacNat 301 Fr	b Fi ede	uneral Horick Road	ome, P. d Cat	A. onsv	ille	, MD	21228
8760,	ate be nysicie he bur	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Sub Due to (or as a Due to (or as a Due to (or as a Due to (or as a	parach a conseq erebr a conseq	moid Hen uence of): ral Arter uence of):	norrhag	je						Interval Between Onset and Death
P.O. Box 6	the death certifica y the attending ph iched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I death 3 🗌	Ectopic pre Other (spe					23d. Date Mon		ry Day Year
ords, P	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death bu	it not resi	ulting in the un	derlying ca	use give	n in Part I.			. /		e cause of death? ably 4 □Unknown
al Reco	The ate h page	Completed								24a. Was auto perf 1 V Yes	psy ormed?	pr de	ere autoprior to compath?	osy findings available apletion of cause of 2 No
Division of Vital Records,	ding Phys	ertification; To Be	25. Was case referred to medical examiner? Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		ER/Outpatient 28b. Time of Injury		c. Injury Work	at Hursing H		dence)
Divi	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	OF	3 Suicide 6 Could not be determined	building, etc	. (Specify	<i>(</i>)				City or To	wn, State	a)		Route Number,
	To the Hospital or All within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physical Example (Check only one) 1 ☐ Certifying Physical Example (Check only one)	ysician: To the best of iner: On the basis of and manner stat	examinal	wiedge, death tion and/or inv	estigation, i	п ту ор	e, date and place, inion, death occur number	and due to the red at the time.	date and	d place, as	nd due to	the cause(s)
	60		I him hi.	m.D					.M.E.			uary		2004 2004
	Baldy		30. Name and address of person who concerns the Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control	m.D			TTT	. Per	nn Street	t, Balt	imor	e, Mā	aryla	nd 21201
*	Stat Registra	te ar	31. Date filed (Month, Day, Year) FEB 0 3 2004	32. Hegistra	r s Signa	ture for the	1							

			State of Maryland	Certificate of	Death	Reg. No. 2001	4 02809		
		1. Decedent's Name (First, Middle, Le	st)		2. Dete of	Deeth	3. Time of Death		
	Physiciar /Medica		Ann Hillier		January January 1	ON 427 2004	1 75%		
	Examine	4e Fecility Name (If not institution, give	· ·		4b. City, Town, or Location of De	ath 4c. County of Dea	th		
		Stella Maris Hosp		_	Baltimore	N/A			
	Funeral Director	5. Social Security Number 6. S 216-88-5798 1 Usuel Residence of Decedent	ex	est birthday) If Under 1 Year Months Deys		Birth 9. Bir Day, Year) 9. Bir Co 13, 1960 M	thplace (State or Foreign buntry) [aryland		
	puet #	10a. State 10b. County	10c. City	, Town or Location			10d. Inside City Limits		
	Many Many	Maryland Balti	more	Ra1t	imore		1 ☐ Yes 2 No		
	r 28s	10e. Street and Number		10f. Zip Code	2010	10g. Citizen of What Co	ountry?		
	th wit	3514 Lilac A	Avenue	212	227	US	A		
)	dear dear	11. Maritel Status	12. Was Decedent Ever in U,S Armed Forces?	S. 13. Was Decedent of	Hispanic Origin? (Specify Yes or ban, Mexican, Puerto Rican, etc.)	No- 14. Race - Ame Black, Whit			
Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. To Re Commissed by Eurosca Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Yeer or Detes:	1□ Yes 2XQ No	Specify:		hite		
7	natu natu	15. Decedent's Ed (Specify only highest gre	lucation de completed)	16e. Decedent's Usual Occu (Give kind of work done	petion during most of working ed)	16b. Kind of Business	/Industry		
12	within she.	Elementary/Secondary (0-12)	College (1-4or 5+)	Never Wor	·	NT / A			
9	Hygie ther ant, m	17. Father's Name (First, Middle, Last)		Never wor	18. Mother's Name (First, Midd	N/A			
an	Mentel Hy arked oth attic even	Trevor C. Hil			Virginia	L. Campbel	1		
ary	should Mark	19a. Informant's Name/Relationship (19b. Mailing Address (Stree	t and Number or Rurel Route Num	*			
	alth all	Trevor C. Hillier	/Father	3514 Lilac /	Avenue Baltimore	altimore, MD 21227			
e,	othe othe	20a. Method of Disposition	20b. PI	ace of Disposition (Name of emetery, crematory or other pla	Date Date	20c. Location - City or	Town, State		
Baltimore,	Pege nt: # nry or	1 ☐ Burial 2 MCremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specifi			y, Inc. 1-29-0	Baltim	ore, MD		
alti	mit. partm	21. Signature o eral Service Licen	see <i>D-1</i>	ess of Facility					
Ω	80 1 8	Edward A.	Gregorchik		ion Society o ederick Road				
	SEC.	23a. Pert1. Enter the disease, or shock, or heart failure. List only		. Do not enter the mode of dy	ing, such es cardiac or respiratory	errest,	Approximate Interval Between		
	Physician	SHOOK, OF HEAR TAILUTE. EIST OTHY	one days on dadrine.				Onset and Death		
ч	/Medical Examiner	Immediate Cause (Final disease or condition		erebro va:	scular ac	cident			
		resulting in death)		as a consequence of):					
	sit and		b						
	The lew requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be deteched for use as the buriel-trensit.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequence of):					
68760,	siclar siclar buri	Cause (Disease or injury that initiated events	C. Due to /ce						
89	ificete p phy es the	resulting in death) Last	or of end	as a consequence of):		I			
Вох	eath cert ettendin I for use		d						
-	death	Part II. Other significent conditions of	ontributing to death but not resu	Iting in the underlying cause gi	ven in Part I. 23b. Di	d tobacco use contribute	to the ceuse of death?		
P.0	v requires that the death certiconting been signed by the ettending should be deteched for use etect by Physician/M				1[∐Yes 2□No 3□P	robably 4 Unknown		
	igned be de						•		
ord	equir				24a. Wa	rformed?	Were autopsy findings available prior to		
Records,	The lew requir						completion of cause of death?		
E	The page				12	I Yes 242 No	1 ☐ Yes 2 ☐ No		
Vital	clan: sertific sector		Hospital:		26. Place of Death (Check online)		1		
P	Physic this c ral dire	TE Tes ZE NO	1 □ Inpatient 2 □ E	EN/Outpatient 3LI DOA	4 Li Nursing Home 5 Li Re	esidence 6 Other (Spe e how injury occurred	city) NOSpice		
u o	Attending I at deeth. ector: After by the funer tiffication	1 Natural 5 Pending	(Month, Day Year)	Injury Wo	rk?]Yes 2□No	s now injury occurred			
Division	deet ctor: yy the	2 Accident investigation 3 Suicide 6 Could not be determined		me, farm, street, factory, office		(Street and Number or Ri	ural Route Number,		
\leq	tal or Attending P rs efter deeth. et Director: After t led in by the funera Certification:	4 ☐ Homicide	building, etc. (Specify))	City or 7	own, State)			
4	To the Hospital or Attending Physician: The lew within 24 hours effer deeth. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Compl	29a. Certifier 1 ☐ Certifying Phy (Check only one)	ysician: To the best of my know liner: On the basis of examinati and menner stated.	vledge, deeth occurred et the ti on and/or investigation, in my	me, date and place, and due to the opinion, death occurred at the time	e cause(s) and manner as e, date and place, and due	s stated. e to the cause(s)		
	within To the comp	29b. Signeture and title of certifier	^	29c. Licen	se number	29d. Date/signed (Mont	h, Day, Year)		
	/	> Down In) mo	DHI	0854	1/28/2	004		
	1)	30. Name end address of person who o	completed cause of death (Item	23e) (Type, Print)	0				
1000	***************************************	20112110	every 301	ST Paul P	L Ballimore	= 21202			
	State	31. Dete filed (Month, Day, Year)	32/Registrer's Signet	urb Annual					
	Registrar	FEB 0 3 20	V 1						

DHMH 17 Rev 1/2001

46	ARET HAI	RPI	ER		State of M			ortmont /						-	DIC.		
			1 - For State Registrar		State of M	arylaril		rtificate			ind iv	ieniai n		6	104	0281	-
				e (First, Middle, Last	r)			rimouto	0, 2	Joann		2. Date of D	Reg. N	0.		3. Time of Death	-
	Physici /Medi		Marga	cet m	ae Ha	coe						Month JAN.		ay 200	Year)4	11:08 A	Α
}	Examir		4a. Facility Name (/	f not institution, give	street and number)			4b. City, To	wn, or	Location of	f Death				of Death	1 22000 11	_
				MARITAN H						ORE C							
	Funeral Director		5. Social Security N		X 7. Ag □ M 2	9 (In yrs. I	ast birthday) Yrs.	If Under 1 \	rear Days	If Under 2 Hours	Min.	8. Date of B	irth ay, Yee	2	9. Birthp	place (State or Foreigntry)	n
			Usual Residence of			31						スーク	5-5	5 '		1110	_
	ryland		10a. State	10b. County			, Town or Lo								1	0d. Inside City Limits	
	Ba-f s	cto	Md			13	Balt	imor								1 Pres 2 □ No)
	with the or 2	Dire	10e. Street and Nur					10f. Zip Co		20	2		10g. C	itizen of \	What Coun	ntry?	
	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or itema 23a or 28a-1 show svent, the Midical Examinar must be nutilised at	Funeral Director	11. Marital Status	rest vi	12. Was Decedent	Ever in U.S	S. 13.1		<u> </u>	3 C	_	rify Yes or N	0-	IA Bac	e - Americ	ran Indian	_
9	after or item	Fun		ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ H		1	Was Deceden If Yes, specify	_		Puerto	Rican, etc.)		Blac	ck, White,	etc.	
93	ours a	d by	3 Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🗷	No	Specify:				Specify	131	ack	
5-(n 72 h	Completed	(Spec	15. Decedent's Edu ify only highest grad	ication le completed)		16a. Deced (Give	dent's Usual C kind of work of DO NOT use r	ccupa one di	tion uring most	of workii	ng	16b. I	Kind of B	usiness/Ind	dustry	
12	withir ene. then	dmo	Elementary/Seco		College (1-4or	5+)		me P						Ца.	n e	(
0	e filed of Hygie other i	Be Co	17. Father's Name					145611			's Name	(First, Middle	a. Maide			1	_
/lar	should be nd Mental marked c	To B	Willian	John	Son SR.	i.				Hell	ie	Hos	Horsey				
lan	2 sho and h is ma	i.	19a. Informant's Na	me/Relationship (T)	rpe, Print)		19b. Mailir	ng Address (S	treet ar								_
2	is 1 and if Health itsm 27 other tr			Harper	- 20	not Di	191			lieu			_	omo		1239	
201	nt of h			Cremation 3 🗆 F		C6	metery, cren	sition (Name on attory or other	r place			ate			City or To		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mer Important: If itsm 27 is marke any injury or other traumatic anges.			5 ☐ Other (Specify) neral Service Licens		160		Son For					ne	157	ma		_
Ba	Depa Impo sny ir		· an	esleur	Chan	10	1	Name and A	64	2415	76.	+.H.	a Ita	mo	, 2	1231	
No.			23a. Part1. Enter the	ne disease complet failure. List only o	ications that caused	the death.	. Do not ent	er the mode of	f dying,	, such as c	ardiac o	r respiratory a	rrest,			Approximate Interval Between	_
4	Physician		Immediate Cause (Final	Arterio											Onset and Death	
**	/Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):										
	- Administra	36	Sequentially list con	nditions,	b. — Dus to (o. as	a Colorado	ence of										
	rted	Examiner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or	rlying Injury	000 10 (01 03	a consequi	arica ory.										
ó	te be executed ysician and e burial-transit	Еха	that initiated events resulting in death) L	ast	Due to (or as	a consequ	ence of):										
8760,		cal			d												
9	death certifica e attending ph od for use as ti	Med	IF FEMALE:	30									-1			2011-10-10-	_
Вох	attend for us	lan/	23b. Was decedent in the past 12	pregnant	3c. If yes, outcome 1☐Live birth	2 Fetal	death 3□	Ectopic pregn					196	23d. Dat	e of deliver	ry Day Year	
o.	the de	iyslo	1 ☐ Yes 2 ☐ 9 ☐ Unknown]No	4□Pregnant at 9□Unknown	time of dea	ath 5∟	Other (specif	y)							,	
S, D	The law requires that the ate has been signed by th page 2 should be detache	by Physician/Med	Part II. Other signifi	cant conditions cor	ntributing to death b	ut not resul	lting in the ur	nderlying caus	e given	in Part I.		23e. Did	obacco	use contr	ibute to the	e cause of death?	1
rds	w requires that been signed be should be det											10	Yes 2	□No	3 🗌 Proba	abiy 4) Unknown	
Record	law re as bec 2 sho	Completed										24a. Was		24b. V	Vere autop	sy findings available	1
		Com										auto perfo	psy ormed? 2 No	d	eath?	npletion of cause of 2 No	
Division of Vital	Attending Physician: The laving death. ector: After this certificate has by the funeral director, page 2	Be	25. Was case referr examiner?		lospital:	-					of Death	(Check only		1			
o	Physic ruthis cral dir	. To	1 XYes 2 1	Vo	lospital: 1 ☐ Inpatie 28a. Date of Injui		R/Outpatient 28b. Time of		Cther	4 🗆 Nurs		ne 5 ☐ Resi)	_
O	ding th. After funer	tlon	1 ZNatural 2 ☐ Accident	5 Pending investigation	(Month, Da)	Yeer)	Injury		Injury a Work?	at es 2 □ No		8d. Describe	now inju	ry occurre	∍d		
<u>S</u>	after death after death Director: in by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be	28e. Place of Inju	ury - At hon	ne, farm, stre					8f. Location (Street ar	nd Numbe	er or Rural	Route Number,	-
ā	tal or A	Certification:	4 Li Homicide		building, etc	с. (Бресіту)						City or To	wn, State	e)			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only	1 ☐ Certifying Phys 2 🂢 Medical Exami	sician: To the best oner: On the basis of	of my know examination	ledge, death	occurred at the	ne time	, date and	place, a	nd due to the	cause(s) and mar	nner as sta	ated.	_
	To the within 2 To the complet	Med	29b. Signature and		and manner sta	ted.	^ -	29c. Lic									
	¥ € 8		W.L	A	0 000	R	DO a.	1		.M.E				te signed AN .	(Month, D	2004	
	/X/		Name and addre	ss of person who co	impleted cause of di	ath (Item :	23a) (Type I	13									_
_	M		PATRICIA	Aronica	- Polla	Km	^	Penn	Str	eet,	Balt	timore,	, Ma	ryla	nd 21	201	
	Sta Registr		31. Date filed (Mont	h, Day, Year)	32. Registra	ar's Signatu		,									

			1 - For State Registrar	State of Maryla		artment of H			giene Reg. No. 20	04 02811
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ith	3. Time of Death
	Physici /Medio		Florence		Hyde			Jan.	29, 200	Year 04 3:05 P M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	ath	4c. County of	
			Broadmead			Cocke	ysville		Ва	altimore
	Funeral		Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year)	Birthplace (State or Foreign Country)
П	Director		309-12-05/1	LIM ZAJF	94 Yrs.	,		Sept. 1	1, 1909	WI
	pur *		Usual Residence of Decedent 10a, State 10b, County	10c	City, Town or Lo	ncation				10d. Inside City Limits
	Aaryli Faho	ត	,	timore		ysville				1 ☐ Yes 21X No
	28a-	Director	10e. Street and Number	CIMOTE	COCKE	10f. Zip Code			10g. Citizen of Wh	
	with a or		13801 York Road				20		•	iat Country?
	death with the Maryland ma 23a or 28a-f show f must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in	115 13	Was Decedent of H		Specify Ves or No-	USA 14 Bace	- American Indian.
	ter d	Ë	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No	10.5.	Was Decedent of H. If Yes, specify Cuba	in, Mexican, Pue	irto Rican, etc.)	Black,	White, etc.
5	hours after tural', or Its al Examine	þ	3 ☐ Widowed 4 🕅 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🏋 No	Specify:		Specify:	White
Ş	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "natural", or Itama 23a or 28a-f show avent, I'na Medical Examinar must be notitied at		15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busi	iness/Industry
2	filed within 72 Hygiene. other than "nai ant, the Medic	Completed	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of w ()	orking		•
7	filed withi Hygiene. other than	E	Cidinontary/Socondary (5 12)	5+	Libr	arian			Library	Science
p	othe vent,	ВеС	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,		
<u>a</u>		10 E	Henry Charles V	Volff			Minn	ie Rowle	У	
Maryland 21215-0036	SP E	_	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a				tate, Zip Code)
_			Frances Brown/Frie	end	4906	Crowson A	ve. Ba	ltimore,	MD 21212	
Baitimore,	-IS5	1 3	20a. Method of Disposition	206	. Place of Dispo	osition (Name of		Date	20c. Location - C	
Ē	Pages nent of int: If it	1 3	1 ☐ Burial 2 XCremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State Bay)	altimore remator	matory or other place Washingt	ton Feb	3, 004	Laure1	MD
= =	permit. Page Department Important: If sny injury or once.		21. Signature of Funeral Septice Licen							ley, Inc.
'n	50 5 6		Mich	nael J. Flagl	e 1	emmon Fun O W.Padon	eral Hoi ia Road	ne of Dul Timoniu	aney Val m. MD 21	ley, inc.
6.	5		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de						Approximate
	Physician		Immediate Cause (Final	one cause on each line.	50111	NF D	EN NEN	ITIA		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cons	equence of):	$9/\sqrt{D}$	LIVICI	JIIA		9 years
	Examiner			141		TENIS!	DX/			′
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co s	1	CIVOI				
	uted d ansit	Examiner	i any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events							
<u>,</u>	exection and and rial-tr		resulting in death) Last	Due to (or as a cons	equence of):					
9/PU	death certificate be executed e attending physicien and id for use as the burial-transit	dlcal		d.						
ğ	tifical ig phy as th	ed								
X Q Q	leath certific attending p I for use as I	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		7			23d. Date	of delivery
מ	death e atte d for	icla	in the past 12 months? 1 □ Yes 2 ☑No	1 Live birth 2 □ Fe 4 Pregnant at time o]Ectopic pregnancy] Other <i>(specify)</i>			Month	n Day Year
5	the y th	hys	9 🗆 Unknown	9□ Unknown						
٠, ٦	The law requires that ate has been signed b bage 2 should be deta	by P	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
cords	quire in sig uld b	pe pe	PERIPHERAL	- ARTERI	AL.	DISEAS	SE	1 🗆 Y	es 2 DNo 3	☐ Probably 4 ☐Unknown
ပ္ပ	s bee	Completed	·					24a. Was a	n 24b. We	are autopsy findings available
T T	iician: The lav certificate has rector, page 2	E C						autops perforr	ned? prid	or to completion of cause of ath?
VIII		C	25. Was case referred to medical				OC Place of De			Yes 2 No
	ysician: is certific director,	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatien	nt 3 DOA Othe		eath (Check only on		(0.1%)
ō	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury	28b. Time of			Home 5 Reside	ow injury occurred	
<u> </u>	nding F ith. : After s funera	ig Ig	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		(? Yes 2. □ No		, •	
DIVISION	or Attending Physician: ifter death. Diractor: After this certifici	Certification:	3 ☐ Suicide 6 ☐ Could not be	286. Place of Injury - At	home, farm, str	eet, factory, office	11.276	28f. Location (St	reet and Number	or Rural Route Number,
5	al or afte Dira	ert	4 Homicide determined	building, etc. (Spe	cify)			City or Town	n, State)	
TIP.	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely fi.ed in by the		29a. Certifier 1 ertifying Ph	ysician: To the best of my k	nowledge, death	n occurred at the tim	e, date and plac	e, and due to the ca	ause(s) and mann	er as stated.
X	n 24 in Piere	Medical	(Check only 2 Medical Examone)	niner: On the basis of exami and manner stated.	nation and/or in-	vestigation, in my op	oinion, death occ	urred at the time, d	ate and place, and	d due to the cause(s)
•	To the within To the Comp	ž	29b. Signature and title of certifier	1	. 1	29c. License	number	2	9d. Date signed (i	Month, Day, Year)
	\sim		BANAHA	1 (Axk)	all m	N D	3739	2.	1/20	2/2 mil
	18		30. Name and address of person who	completed cause of death (It	em 23a) (Type.	Print)	_		1101	10009
	`		BARBARA	CARROL	L.M.	0. /39	101 Y	ORK	D. CO	CKFY=UILLE
-6	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature				1	MA
100	Registr	ar	eren 0 0 2004	周	10					' '

ORIGINAL

hysicia	an	Decedent's Name (First, Middle, I	Lasi)	11:	CKS			2. Date of Death Month	Day	Year	3. Time of De
/Medic		TREGONN	A	,,				January	_	2004	17:44
xamin	er	4a. Facility Name (If not institution, g		ber)			ocation of Dea	tn	4c. Co	unty of Deeth	n
<u> </u>		832 Washington B 5. Social Security Number		'. Age (In yrs. las		Baltimo der 1 Year	If Under 24 Hr	8. Date of Birth		9. Birth	nplece (State or Fountry)
neral ector		Usual Residence of Decedent	1□ M 2 🗷 F	27	Yrs. Month	ns Days	Hours Mir	8. Date of Birth (Month, Day,	76	Col	md.
No.	_	10a. State 10b. County			Town or Location						10d. Inside City L
er, or neme 23s or 28s-1 show Examiner must be notified at	Funeral Director	10e. Street and Number		<i>D</i> .	19/10 10f.	Zip Code		11	Og. Citizen	of What Co	
ust be	ai D	832 WAShir	Naton	BLV	d.	210	230		4	1.5.	A.
rerm	ner	11. Marital Status	Armed Ford	dent Ever in U.S.	13. Was De	cedent of Hisp	panic Origin? (Mexican, Pue	Specify Yes or No- rto Rican, etc.)		Race - Amer Bleck, White	
, or m	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced		No No			Specify:	, , , , , , , , , , , , , , , , , , , ,		ecity:	IACK
Jical Ex	ted b	15. Decedent's	Education		16a. Decedent's U	sual Occupati	ion		16b. Kind	of Business/I	Industry
200	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4	4or 5+)	(Give kind of life. DO NO)	work done dui Tuse retired)	ring most of w	orking		. /.	./
d other than event, the M	Con	12th				Cler				efp.	12
svant, II	Be	17. Father's Name (First, Middle, La	A. Hic	K		1	18. Mother's Na	me (First, Middle, N	faiden Sui	mame)	0/
marked matic s	ဥ				405 84-10- 444	(6)	BAR	BRA	<u> </u>	NOF	Y Contain
trau		19a. Informant's Name/Relationship	(Type, Print)	,	19b. Mailing Addre		Ala l'	Lar Mile Number,	BA	/ Ta	ip Code) M. 214
other 1		20a, Method of Disposition	EMURY	20b. Plac	ce of Disposition (A	Name of	140114	Date	20c. Locati	ion - City or 1	Town, Stete
= 5		1 Burial 2 Cremation 3		cem	netery, prematory of			20 01	A FASS	1/2	It asola
mportent: iny injury ince.		`4 □Donation 5 □Other (Spe		, /	14. [B	RME	/ /-	48-04	UM	1/14/1	11000
any ir		21. Signature of Funeral Service Lic	oensee/	7 ,	22. Name	S/PU	KAUIS	534. FO	NER		200
= = a !		AIIDA VA.AII	1// 1//		0000						
E = a	11	Wesley	Kanto	used the death	20	OF E	AST1	IN AVE.	BAI	10.1	Approximate
= = a		23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications at cally one cause on ea	used the death. ch line.	Do not enter the m	of tying,	A STT such as cardia	C or respiratory arre	BB B B	(10.7	Approximate Interval Betwee Onset and Dea
sicían		Immediate Cause (Final disease or condition			Do not enter the m				BBI ist.	K 10.1	
sicían edical		Immediate Cause (Final	a. Narco		ine and alo				SS.	K 10.7	Interval Between
sicían		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Narco Due to (o	r as a consequer	ine and alc				SA.	K 10.7	Interval Between
sician edical niner	liner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	a. Narco Due to (o	tic, cocai	ine and alc				SAI.	K 10.7	Interval Between
sician edical niner	kaminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Narco Due to (o b. Due to (o	r as a consequen	ine and alconce of):				BA A	K 10.1	Interval Between
sicían edical niner	il Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Narco Due to (o b. Due to (o	r as a consequer	ine and alconce of):				BA A	K 10.1	Interval Between
sician and dical interest and printer sicial interest and printer sicial interest and printers a	cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Narco Due to (o b. Due to (o	r as a consequen	ine and alconce of):				ps.	K 10.7	Interval Between
sician and dical interest and printer sicial interest and printer sicial interest and printers a	cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:	a. Narco Due to (o b. Due to (o c. Due to (o	r as a consequent	ine and alconce of): nee of): nee of):					K 10.7	Interval Betwee
dung physicien and sicians the burial-transit as the burial-transit as as the burial-transit as a second sicial second se	cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce	or as a consequent or a consequent or	ine and alconce of): nce of): nce of):	cohol int				Date of deline	Interval Betwee
dung physicien and sicians the burial-transit as the burial-transit as as the burial-transit as a second sicial second se	cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent of the consequent of pregnance of the consequent of the conse	ine and alconce of): nce of): nce of):	cohol int					Interval Betwee Onset and Dea
y the attending physicien and according to the burial-transit actions as the burial-transit actions.	cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent as a consequent at time of deather at time of deather as a consequent at time of deather as a consequent at time of deather as a consequent as	ine and alconce of): nce of): ry eath 3 Ectopic th 5 Other	ephol int	toxicatio	on	23d.	Month	Interval Betwee Onset and Dea
y the attending physicien and according to the burial-transit actions as the burial-transit actions.	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent as a consequent at time of deather at time of deather as a consequent at time of deather as a consequent at time of deather as a consequent as	ine and alconce of): nce of): ry eath 3 Ectopic th 5 Other	ephol int	toxicatio	23e. Did tob	23d.	Month	very Day Yea
y the attending physicien and according to the burial-transit actions as the burial-transit actions.	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent as a consequent at time of deather at time of deather as a consequent at time of deather as a consequent at time of deather as a consequent as	ine and alconce of): nce of): ry eath 3 Ectopic th 5 Other	ephol int	toxicatio	23e. Did tob	23d. acco use 6	Month contribute to	very Day Year the cause of deat
s been signed by the attending physicien and 2 should be detached for use as the burial-transit 1 au 1 au 1 au 1 au 1 au 1 au 1 au 1 a	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent as a consequent at time of deather at time of deather as a consequent at time of deather as a consequent at time of deather as a consequent as	ine and alconce of): nce of): ry eath 3 Ectopic th 5 Other	ephol int	toxicatio	23e. Did tob 1	23d. acco use 6	Month contribute to	very Day Yea the cause of deat babably 4 Unkn
ale has been signed by the attending physicien and page 2 should be detached for use as the burial-transit and the united page 2 should be detached for use as the burial-transit and the united page 2 should be detached for use as the burial-transit and the united page 2 should be detached for use as the burial-transit and the united page 2 should be detached for use as the united page 2 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use 3	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent as a consequent at time of deather at time of deather as a consequent at time of deather as a consequent at time of deather as a consequent as	ine and alconce of): nce of): ry eath 3 Ectopic th 5 Other	ephol int	toxicatio	23e. Did tob	23d. acco use 6 s 2 \(\text{N} \)	Month contribute to	very Day Yea the cause of deat babably 4 Unkn
ale has been signed by the attending physicien and page 2 should be detached for use as the burial-transit and the united page 2 should be detached for use as the burial-transit and the united page 2 should be detached for use as the burial-transit and the united page 2 should be detached for use as the burial-transit and the united page 2 should be detached for use as the united page 2 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use as the united page 3 should be detached for use 3	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outcut 1	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent as a consequent at time of deather at time of deather as a consequent at time of deather as a consequent at time of deather as a consequent as	ine and alconce of): nce of): ry eath 3 Ectopic th 5 Other	c pregnancy (specify)	toxication	23e. Did tob 1	23d. acco use 6 s 2	Month contribute to 3 Pro 4b. Were aul prior to c cean? Yes	very Day Yea the cause of deat babably 4 Unki
Is certificate has been signed by the attending physicien and director, page 2 should be detached for use as the burial-transit and a left of the contract of	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow s contributing to dea	or as a consequent or as a consequent or as a consequent or as a consequent of pregnance the 2 Fetal dental time of death with the consequent of the consequ	ine and alconce of): nce of): ry eath 3 Ectopic th 5 Other	ephol into	toxication in Part I. 26. Place of Dec. 4 \(\triangle \triangl	23e. Did tob 1	23d. acco use 6 s 2 N 1/10d? No	Month contribute to lo 3 Pro 4b. Were au prior to c death? Yes	very Day Yea the cause of deat babably 4 Unki
Itler this certificate has been signed by the attending physician and injury in a contract of the page 2 should be detached for use as the burial-transit and a large transit and a large	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Narco Due to (o b. Due to (o c. Due to (o d. Pregna 9 Unknow s contributing to dea	or as a consequent or as a consequent or as a consequent or as a consequent of pregnance the 2 Fetal dental time of death with the consequent of the consequ	ine and alconce of): nce of): yeath 3 Ectopic th 5 Other and of the underlyine	e pregnancy (specify) g cause given Other: 28c. Injury a	toxication in Part I. 26. Place of Dec. 4 \(\text{Nursing} \)	23e. Did tob 1	23d. acco use 6 s 2 N 1/10d? No	Month contribute to lo 3 Pro 4b. Were au prior to c death? Yes	very Day Yea the cause of deat babably 4 Unki
Itler this certificate has been signed by the attending physician and injury in a contract of the page 2 should be detached for use as the burial-transit and a large transit and a large	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow s contributing to dea	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent at time of deat with a consequent at time of deat with the consequent of the co	ine and alconce of): nce of): nce of): ay ay ath 3 Ectopic th 5 Other ay ayOutpatient 3 8b. Time of Injury M Unknown M	c pregnancy (specify) g cause given 28c. Injury a Work? 1 □ Ye	toxication in Part I. 26. Place of Dec. 4 \(\text{Nursing} \)	23e. Did tob 1	23d. acco use 6 % 2 Nod? Once 6 % winjury oc	Month contribute to 3 Pro 4b. Were aui prior to c gath? Other (Spec	very Day Yea the cause of deat bbably 4 Unker topsy findings ava completion of caus 2 No
Itler this certificate has been signed by the attending physician and injury in a contract of the page 2 should be detached for use as the burial-transit and a large transit and a large	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow s contributing to dea Hospital: 1 In In 1/19/0 t be 28e. Place of	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent at time of deat with a consequent at time of deat with the consequent of the co	ine and alconce of): nce of): nce of): sy	c pregnancy (specify) g cause given 28c. Injury a Work? 1 □ Ye	toxication in Part I. 26. Place of Dec. 4 \(\text{Nursing} \)	23e. Did tob 1	23d. acco use 6 % 2 Nod? Once 6 % winjury oc	Month contribute to 3 Pro 4b. Were aui prior to c gath? Other (Spec	very Day Yea the cause of deat babably 4 Unki
Itler this certificate has been signed by the attending physician and injury in a contract of the page 2 should be detached for use as the burial-transit and a large transit and a large	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	A. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow s contributing to dea Hospital: 1 In In tion t be ed 28a. Date of (Month 1/19/0 28e. Place of building Home	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent of as a consequent of as a consequent of pregnance of	ine and alconce of): nce of): nce of): ry eath 3 Ectopic th 5 Other ry ong in the underlying R/Outpatient 3 Bb. Time of Injury Unknown M e, farm, street, fact	pregnancy (specify) g cause given Other: 28c. Injury a Work? 1 □ Ye	toxication in Part I. 26. Place of De 4 \(\text{Nursing} \) at as \(\frac{1}{24} \) No	23e. Did tob 1	23d. acco use 6 s 2 N log 2 log 2 log 2 log 3 log 6 w injury oc eet and W State) 82	Month contribute to a Pro 4b. Were au prior to c death? Yes Cother (Special Courred) washi	very Day Yea the cause of deat bably 4 Unki topsy findings ava completion of caus 2 No SCENE
Itler this certificate has been signed by the attending physician and injury in a contract of the page 2 should be detached for use as the burial-transit and a large transit and a large	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	A. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow s contributing to dea Hospital: 1 In In 28a. Date of (Month 1/19/0 28e. Place obuilding Home Physician: To the base	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent of as a consequent of pregnance of pregn	ine and alconce of): nce of): nce of): eath 3 Ectopic th 5 Other country the underlying in the underlying in the underlying the underlying in the und	c pregnancy (specify) g cause given Other: 28c. Injury a Work? 1 □ Ye tory, office	toxication in Part I. 26. Place of De 4 \(\text{Nursing} \) at at at at at at at at at a	23e. Did tob 1 Ye 24a. Was ar autops: perform 24 Yes 2 Path (Check only one 28d. Describe ho Unknown 28f. Location (Str. City or Town Baltimore e, and due to the ca	23d. acco use of s 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2	Month contribute to lo 3 Pro 4b. Were aul prior to c death? A Yes Courred courred d manner as	very Day Yea the cause of deat babably 4 Unki topsy findings ava completion of caus 2 No stated.
Itler this certificate has been signed by the attending physician and injury in a contract of the page 2 should be detached for use as the burial-transit and a large transit and a large	edical Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	A. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow s contributing to dea to the to be ded 1/19/0 28e. Place of building Home Physician: To the be	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent of as a consequent of pregnance of pregn	ine and alconce of): nce of): yeath 3 Ectopic th 5 Other th 5 Other the underlying in the unde	cohol into pregnancy (specify) g cause given Other: 28c. Injury a Work? 1 □ Ye lory, office	toxication in Part I. 26. Place of Dec. 4 \(\text{Nursing} \) at the set \(\frac{24}{24} \) on, date and place only, death occurrence, death occurrence, death occurrence, and the control of the control occurrence.	23e. Did tob 1	23d. acco use s 2 N acco use s 2 N acco use 6 X acco u	Month contribute to 3 Pro 4b. Were au prior to c death? 10 Yes Courred courred d manner as ice, and due	very Day The cause of deat bably 4 Unker topsy findings ava completion of caus 2 No SCENE Tal Route Number ington BIVO stated. to the cause(s)
Is certificate has been signed by the attending physicien and director, page 2 should be detached for use as the burial-transit and a left of the contract of	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	A. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow s contributing to dea Hospital: 1 In In 28a. Date of (Month 1/19/0 28e. Place obuilding Home Physician: To the base	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent of as a consequent of pregnance of pregn	ine and alconce of): nce of): yeath 3 Ectopic th 5 Other th 5 Other the underlying in the unde	c pregnancy (specify) g cause given 28c. Injury a Work? 1 □ Ye tory, office ed at the time, ion, in my opin 29c. License r	toxication a in Part I. 26. Place of De 4 \(\text{Nursing} \) at as \(\frac{1}{2} \text{No} \) b, date and place nion, death occurrence number	23e. Did tob 1	23d. acco use s 2 N acco use s 2 N acco use 6 X acco u	Month contribute to lo 3 Pro 4b. Were aul prior to c death? A Yes Courred courred d manner as	very Day The cause of deat bably 4 Unker topsy findings ava completion of caus 2 No SCENE Tal Route Number ington BIVO stated. to the cause(s)
Itler this certificate has been signed by the attending physician and injury in a contract of the page 2 should be detached for use as the burial-transit and a large transit and a large	edical Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	A. Narco Due to (o b. Due to (o c. Due to (o d. 23c. If yes, outce 1 Live bir 4 Pregna 9 Unknow s contributing to dea Hospital: 1 In In 28a. Date of (Month 1/19/0 28e. Place obuilding Home Physician: To the base	or as a consequent or as a consequent or as a consequent or as a consequent or as a consequent of as a consequent of pregnance of pregn	ine and alconce of): nce of): yeath 3 Ectopic th 5 Other th 5 Other the underlying in the unde	c pregnancy (specify) g cause given 28c. Injury a Work? 1 □ Ye tory, office ed at the time, ion, in my opin 29c. License r	toxication in Part I. 26. Place of Dec. 4 \(\text{Nursing} \) at the set \(\frac{24}{24} \) on, date and place only, death occurrence, death occurrence, death occurrence, and the control of the control occurrence.	23e. Did tob 1	acco use of s 2 No 2 No 2 No 2 No 2 No 2 No No	Month contribute to 3 Pro 4b. Were au prior to c death? 10 Yes Courred courred d manner as ice, and due	very Day Yea the cause of deat bbably 4 Unki topsy findings ava completion of caus 2 No SCENE ral Route Number rated to the cause(s) to Dey, Year)

			For State Registrar	State of Maryla		artment of H			giene Reg. No. 20	04 02813
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) JUAN ITA 4a. Facility Name (If not institution, give s	E.	H	UMPHA An Situ Town of	Location of Deat	2. Date of Dea	Day	3. Time of Death
	Examir Funeral	er	Northwest Hospit 5. Social Security Number 6. Sex	al	rs. last birthday) Yrs.		L1stown If Under 24 Hrs Hours Min.	8. Date of Birt	Balt:	imore 9. Birthplace (State or Foreign Country)
	Director works	٥٢	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo			Sept. 2	24, 1937	Maryland 10d. Inside City Limits 1 □ Yes 2√2 No
"	be filed within 72 hours after death with the Maryland hal Hygiene. Indocther than "natural", or Items 23a or 28a-f show event, I'te Medical Exerterest be multilled at	Funeral Director	Maryland Anne Art 10e. Street and Number 619 Luther Stree 11. Marital Status 1 □ Never Married 2 Married		i	10f. Zip Code 2122 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer		Black,	nat Country? - American Indian, White, etc.
21215-0036	e filed within 72 hours a al Hygiene. other than "natural", or vant, I'le Medical Exum	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 10th	If Yes, Give Year or Dates:	16a. Dece (Give life.	1 ☐ Yes 2X No dent's Usual Occup kind of work done of DO NOT use retired emaker	Specify: ation during most of wo	rking	Specify: 16b. Kind of Busi Own Hor	·
Maryland 2	should be filed of Mental Hygin markad other imatic evant, II	To Be C	17. Father's Name (First, Middle, Last) William				Anı	na Ellis	Maiden Surname,	
	s 1 and 2 sh of Health and itam 27 is rr other traum		19a. Informant's Name/Relationship (Ty, Arlie Humphrey / 20a. Method of Disposition	Husband	619 L	ng Address (Street of Luther Sti esition (Name of matory or other place	reet 1		e, Maryla	and 21225 ity or Town, State
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Mente Important: If Itam 27 is markad any injury or other traumatic e once.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License	C	edar Hil	ll Cemete	ry 2/4/	once Fun	eral Ser	e, Maryland vice, P.A. Maryland 21225
8760,	hysician and hysician and hysician and the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the de e cause on each line. Due to (or as a constitution of the constitution of the cause of the cau	requence of): 1 ilos	er the mode of dyin New t and or s	g, such as cardia Laulu My D p Ca			Approximate Interval Between Onset and Death
P.O. Box 6	the death certific by the attending pached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mm/hths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Monti	
Records, P	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant conditions cor	stributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	1 🗆 Y	′es 2□No 3	
	ian: The law rtificate has b tor, page 2 si	Be Completed	25. Was case referred to medical				26. Place of De		rmed? de 2DNo 1D	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Division of Vital	Attending Physician: The r death. sctor: After this certificate his cottificate his yithe funeral director, page	Certification: To E	27. Manner of Death 1 Natural 5 Pending investigation	ospital: Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatier 28b. Time o	f 28c. Injun Worl	4 🗀 Nursing r		lence 6 □Other now injury occurred	
DİXİ	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: o mpletely filled in by the		4 ☐ Homicide determined 29a. Certifier 1☑ Certifying Phys	28e. Place of Injury - A building, etc. (Special and To the best of my	cnowledge, deat	h occurred at the tin	ne, date and place	City or Tow	m, State) cause(s) and mann	or Rural Route Number,
	To the Ho within 24 To the Fu	Medical	(Check only 2 Medical Examinate) 29b. Signature and title of certifier 30. Name and address of person who co	and manner stated. Mahammer stated.		29c. Licenso				Month, Day, Year)
DI	Sta Registr	ar	Gnick All Month, Day, Year) FEB 0 3 2004	32. Registrar's Signary	DRIVE	A 1 A	wani-,	21	<i>Db1</i> .	

			For State	State of Marylan				ental Hyg	giene 20	04	02814
			Registrar 1. Decedent's Name (First, Middle, Last)		Centit	icate of E		2. Date of Dea	Reg. No.		3. Time of Death
	Physici		Charles Willia	m Harry, S	Sr.			Month	Day	Year Ooy	1905 M
	/Medic Examin		4a. Facility Name (If not institution, give str			. City, Town, or	Location of Death	J	4c. County o	f Death	., - 3
			SMINT AGNES!	YEAUTHCARE	5		MORE				
	Funeral		5. Social Security Number 6. Sex 1215-16-0449	7. Age (In yrs. 1		Under 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Day	, Year)	Coun	* i_
	Director		Usual Residence of Decedent		5			Jan. 12	2, 1921	Mar	yland
	ryland	_	10a, State 10b. County	10c. City	y, Town or Location	on				11	Od. Inside City Limits
	Be-f	Director	Maryland Howard		Elkridge						1 ☐ Yes 🏋 No
	with to	Dir	10e. Street and Number 7240 Montgomery Ro	ad Apt. 2A	1	of. Zip Code 2107	75		10g. Citizen <i>o</i> f Wi United		
	death ms 23	Funeral		. Was Decedent Ever in U.	S. 13. Was	Decedent of His	spanic Origin? (Spec	ity Yes or No-	14. Race	- Americ	an Indian,
g	after or ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		s, <i>s</i> pecny Cubar Ye <i>s</i> 2 1∑ No	n, Mexican, Puerto R Specify:	iican, etc.)	Specify:	, White, i	ite
21215-0036	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:							
rç.	in 72 n "na n "na	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	(Give kind	s Usual Occupa ' of work done di VOT use retired)	urina most of workin	9	16b. Kind of Bus	iness/inc	dustry
212	d with	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	Flight	Engine	er		Air F	orce	
5	be file tai Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame)	
Marvland	d 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 77 is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Medical Examiner must be multiled at	ပ	Oscar P. Harry 19a. Informant's Name/Relationship (Type	Print)	10h Mailing A	ddraes (Straat a	Emma Mer		r City or Town C	toto Zin	Cadal
2	nd 2 sl lith an 27 is r traur		Judith Harry - Wife	-	1	nt comer					MD 21075
نه	is 1 and 2 of Health is item 27 is other tra		20a. Method of Disposition	20b. P	lace of Dispositio	n (Name of	Da		20c. Location - C		
<u>.</u>	Page ment c ant: Iff ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren '4 ☐ Donation 5 ☐ Other (Specify)	noval from State	t. Wash.		2/2/	04	Laurel,	Mar	yland
Baltimore.	permit. Pages 1 Department of H important: if ite any injury or ot		21. Signature of Funeral Service Licensee			me and Address	s of Facility Ifman Fune	ral Hon	ne At MMi	P	Inc.
_	20.5 60	i X	23a. Part1. Enter the disease, or complica	tions that caused the death	Gary 7250		fman Fune gton Blvd			aryl	and 21075 Approximate
	Physician		shock, or heart failure. List only one immediate Cause (Final	cause on each line.		,			001,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence)	uence of):	MET TES	ne ma	24 175			hour
	Examiner		Sequentially list conditions, b.	Hypertens.						-	Loyear
	per list	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
_	be executed sicien and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					_	
8760.	cate be executed physicien and the burial-transit	dicai	d								
9		Med	IF FEMALE:								
Вох		Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ect	opic pregnancy ner (specify)			23d. Date Mont		ry Day Year
30	at the de by the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	sath 5LJOH	ier (specity)					
SP	res that igned b	by Pt	Part II. Other significant conditions contri	buting to death but not resu	ulting in the under	lying cause give	n in Part I.	23e. Did to	bacco use contrib	ute to th	e cause of death?
HA ords	w require been sig should b		Artenocelerate con	diovaria	direc	· 5e		1 🗆 Y	es 2□No 3	Proba	ably 4 Gonknown
C1 9	e law re has be- le 2 sho	Completed	Dinbeter					24a. Was a	sy pri	or to con	psy findings available inpletion of cause of
) E								perform 1 ☐ Yes	2 40 1 1	ath?] Yes	2 □ No
Vital	Physician: this certific	To Be	25. Was case referred to medical examiner?	spital: 1 ☐ Inpatient 2 ☑	FR/Outnatient 3	Other	26. Place of Death r: 4 ☐ Nursing Hom			(Specific	
30			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 28		ow injury occurred		/
Z lois	Attending r death. ector: After by the funer	catic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆 Y	es 2□No				
H	oi or Atteno after death Director: d in by the i	ertification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, street,	factory, office	28	3f. Location (Si City or Town	treet and Number n, State)	or Rural	Route Number,
lund	To the Hospitel or A within 24 hours after To the Funeral Direc completely filled in by	O	29a. Certifier 1 Certifying Physic	ian: To the best of my kno	wledge, death occ	curred at the time	e, date and place, ar	nd due to the c	ause(s) and mani	ner as sta	ated.
×	the Ho iin 24 the Fu ipletely	ledical	(Check only 2 Medical Examine one)	r: On the basis of examinal and manner stated.	tion and/or investi	gation, in my opi	inion, death occurred	d at the time, d	ate and place, an	d due to	the cause(s)
	Mith To	Σ	29b. Signature and title of certifier	no france la	7	29c. License			9d. Date signed		
	1/4		30. Name and address of parson who some	nleted cause of death (It-	23a) /Tuna Bris) /L	AGNER	Hoer	in 1	6	, 2009
	10		30. Name and address of person who com Note A Crumell	NO GOS CO	to Au	nue 1	Salhmore	rid	2122	5	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa				*			
	Registr	ar	FEB 0 3 2004	was and with the state of the s	MARTINE						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ANUARYAB 11215 FRAMEIS 4004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMOR G.LCHRISI 101 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months MM 20F 23 1931 HTUDE MKOTA Director 03-09-3381 DEVAL Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show sust be notified at 1 ☐ Yes 2 No Director 12RY 200 monioni 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 .S.A KOAC MBURY 21093 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? T⊠Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or itams 11. Marital Status the Medical Exertiner: Black, White, etc. hours after 1 Never Married 250 Married Maryland 21215-0036 If Yes, Give Year or Dates: W. W.II 1 ☐ Yes 2 No Specify: þ WHILL 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene, important: If Item 27 is marked other then any injury or other trainment. College (1-4or 5+) Elementary/Secondary (0-12) ENGINES R METALLURGIL 127RS-47RS-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be H402 ETAREULE ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) HYOZ KOAO 11 IFRY AND -Ucona LIVE Baltimore, 20c. Location - City or Town, Stete Date 20a. Method of Disposition JAN. 3 1 🗷 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) DUTELEANATIEA 3004 22. Name and Address of Facility ATT 122 21. Signature of Euner II Service License Fur Da 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): MOWDAS /Medical **Examiner** infection Ohude months Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 300 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Wher (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 1 ☐ Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō within 24 hours of To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Peq. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8303 26 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Baltimore MD 21204 4601 N. Charles Charles mo NON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 2 2004 Registrar

			1- State Registrar	25, 全种 ,28		dheDeB		9 5H	galth and	•		e2 0	04	02816
			1. Decedent's Name (First, Middle,		,					2. Date of D	eath		V	3. Time of Death
	Physici /Medio		MELVIN JI	40BS	>					Janua	ing	38,3	2004	1:35pm
	Examin		4a. Fecility Name (If not institution,		mber)		4b. City, T	2 1	Location of De			c. County of	of Death	•
		- 9		neral	HOSDIA	-al	120		more					
	Funeral Director		5. Social Seedrity Number 218-44-4459	Sex 10 M 2 ☐ F	7. Age (Ith yrs. 56	last birthday) Yrs.	If Under 1	Days	If Under 24 H Hours M	in. (Month, L	ay, Year			ece (State or Foreign try)
			Usual Residence of Decedent		50		LL			06/25	/194	/	Mary	Land
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10	Od. Inside City Limits
	Ba-f.s	cto	Maryland Baltim	ore	Т	owson								1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip (10g. C	itizen of W	hat Coun	try?
	death with the Maryland ims 23s or 28s-f show ir must be notified at	rai	4 Asgard Court	10 Was Dass	alana Princip II	S 140		1234		/C1-V		5.A.		a Ladia
10	Item Iner	by Funerai	11. Marital Status 1 Never Married 2 Married	Armed Fo		.5. 13.	If Yes, speci	rfy Cuba	n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	10-		- America c, White, e	
V. n 215-0036	hours after turs!', or Ita	by	3 Widowed 4 Divorced	If Yes, Giv Year or D	/8		1 Yes 2	. □ X No	Specify:			Specify:	B1a	ick
50	72 ho	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual	Occupa	ation	working	16b. I	Kind of Bus	siness/Ind	ustry
> 2	within 72 ene. than "nat	nple	Elementary/Secondary (0-12)	College (1	-4or 5+)			e retired	furing most of w	voi kii ig				
2 6	e filed within al Hygiene. I other then '	S	1 Z 17. Father's Name (First, Middle, La	nt)		Lab	orer		10 Matheda N	lana (Fire Middle		eel		
and	ould be fi Mental H arked ot atic svsr	Be	Jasper Jacobs	51)					18. Mothers N	lame (First, Middl Jeanett)	
Z =	2 should be n and Mental I s marked or raumatic sv	2	19a. Informant's Name/Relationship	(Type, Print)		19b Maili	no Address	(Street	and Number or	Rural Route Num			State Zin	Codel
Jacobs F Itimore, Maryla	iges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. If item 27 is marked other than "naturst, or items 23a or 28a-f show or other traumatic event, if a Madical Examinar must be notified at		Tylia Worthington		nter				9	Marylan			J. L. C. J. J.	0000,
€ e	f Head item other	- 3	20a. Method of Disposition		20b. F	Place of Dispo cometery, crea	osition (Name	e of	10.00011	Date		ocation - (City or Tov	vn, Stete
2 E	Page Tent of Int: If		1 🖾 Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe		State	. Zion				06/2004	Land	lsdow	ne, M	laryland
Da cek	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.	l n	21. Signature of Funeral Service Lie	censee					s of FacilityTh	e Derric	k C.	Jone	es F/	H, P.A.
	Ded Imp	5 11	July 1	(.)		_ 46	11 Par	ck H	gts. Av	e., Balt	imor	e, Ma	aryla	nd 21215
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that c ly one cause on e	used the deat ach line.	h. Do not ent	ter the mode	of dyin	g, such as card	iac or respiratory	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	- a Pneu	monio	2 Ric	ant		na				İ	Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	,							
13		r.	Sagrientially list conditions if any, leading to immediate	b. Due to (or as a conseq	uence of):			-1	de de	16,	CAL		
	uted 1 ansit	Examiner	Sacientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						1 Le	de BY	MEDICAL	INE		
Ć,	tificate be executed g physician and as the burial-transit	Exa	resulting in death) Last	c. Due to (or as a conseq	uence of):			CERTIFICATI	ONLOGICALITY				
,092	ite be iysicië ne bu	ical		d					VE-1-					
989	Physician: The law requires that the death certifica this certificate has been signed by the attending phiral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:								(1			Commission of the Carlo
Box	attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?		inth 2 ☐ Feta	I death 3	Ectopic pre					23d. Date Mons		y Day Year
0.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9☐ Unkno	ant at time of down	eath 5	Other (spe	cify)						
7 0	es that the digned by the be detached	4	Part II. Other significant condition:	contributing to de	eath but not res	ulting in the u	nderlying ca	use give	on in Part I.	23e. Did	tobacco	use contri	bute to the	cause of death?
to b	luires l signe	d b	Quadriplegia.	Diabetes	Melli	tru				1 🗆	Yes 2	□No :	3 🗌 Proba	bly 4 Donknown
\mathcal{L} \mathcal{L} Records,	s been s should	lete								24a. Wa		24b. W	ere autop	sy findings available
A Se	The la te has	ошь								heq	ormed?	pr	ior to come ath?	pletion of cause of
ital	sician: The law certificate has t rector, page 2 s	BeC	25. Was case referred to medical	1					26. Place of D	1 ☐ Yes eath (Check only) 10	res a	2 NO
3 5	Physic this ce al direc	2	examiner? 1X Yes 2 No	Hospital: 1	npatient 2 -	ER/Outpatier	nt 3 DOA	Othe	r: 4 Nursing	Home 5□Res	idence	6 Other	r (Specify)	
	of Prince of American		27. Manner of Death → Chatural 5 Pending		of Injury h, Day Year)	28b. Time of Injury		lc. Injury Work	?	28d. Describe			d	
sio	tending I Jeath. tor; After the funer	cati	2 Accident investigat 3 Suicide 6 Could no	he		Unkno			es 2X No	Subjec				
Division	or Al after of Direction by	Certification; To	4 Homicide determine	ed 28e. Place buildir	of Injury · At hong, etc. (Specify	ome, farm, str y)	eet, factory,	office		City or To	wn, State	nd Numbe e)	r or Rural	Route Number,
K -	Hospitel 4 hours a 5-unerel l ety filled		29a. Certifier 17 Certifying	Unknown Physician: To the		wledge deat	h occurred a	t the tim	e date and pla	Unknow) and man	nor as sta	tad
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director; After this certificate his completely filled in by the funeral director, page	Medicai	(Check only 2 ☐ Medical Ex	aminer: On the ba and mann	isis of examina	tion and/or in	vestigation, i	in my op	inion, death oc	curred at the time	, date an	d place, ar	nd due to	the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier		/		29c.	License	number		29d. Da	ite signed	(Month, D	lay, Year)
			1/2/	15	16		8	398	503		i	28	IOL	<i>t</i>
			30. Name and address of person wh	o completed caus	of death (Item	1 23a) (Type,	Print)	Geo	- 1	A	N.	1 1 30	257. 4	\
-			marneet	ingh	LLD	30 (1	ary	(C)	nd (ornera	4	Ho	SOTH	al
	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signa	tal trans	, .							
DH	MH 17 Rev 1/2	-	FEB 0 3	2004	Bur ,	S. A.	me!						-	
3,,						ORIGIN	AL							

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] AMEND ITEM #6 PER FH G828 2/24/04 Contificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Marie Jones Katherine 26,2004 annavu /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Hospital Baltimore Baltimore City If Under 1 Year | If Under 24 His. | Months | Days | Hours | Min. ^{Year)}52 8. Date of Birth (Month, Day, 02 09 Birthplace (State or Foreign Country)
 L 5. Social Security Number Sex 2KXF 7. Age (In yrs. last birthday) **Funeral** Yrs 51 546-02-4662 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Exercices must be notified at 1 Yes XXNo Directo Owings Mills Baltimore 10g. Citizen of What Country? 10e. Street and Number U.S.A. 108 Egypt Farms Road 21117 or Itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. I∐Yes 2⊠No 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ If Yes, Give Year or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry rthan Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed with Heelth and Mental Hygiene. V.I.P.S. 12th grade 4yrs Lead Funtional Analyst Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Katherine Smith William T. Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Imperial Beach, CA 91933 P.O. Box 184 Mickey Jones-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or otl 1 5 Burial 2 Cremation 3 Removal from State Rose Hil ls Park Donation 5 Other (Specify) 2/9/2004 Whittier, CA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final Malignant History towa **Physician** 2 years disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examine Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 █ No 1 Yes 2. No in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Thipatient 2 ER/Outpatient 3 DOA Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident after death Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Hoapital or 24 hours a 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-600 26,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimere Ballardi Singi Joy EI M.D. \$2. Registrar's Signature 31. Date iled (Month, Day, Year) State 3 2004 Registrar

3

Katherine

Patient

			1 - For State Registrar	State of Maryla		artment of He				04 0281	8
	Di		Decedent's Name (First, Middle, Last)	Plinchath			-	2. Date of De		3. Time of Death	
	Physici /Media			Elizabeth	H. KO			Jan.		04 7:00p	Λ
	Examir	er	4a. Fecility Name (If not institution, give a 606 Riverside	· ·		4b. City, Town, or Lo			4c. County o		
	Funeral		5. Social Security Number 6. Sea		s. last birthday)		f Under 24 Hrs.	8. Date of Birt		imore 9. Birthplace (State or Foreig Country)	רונ
п	Director		2.3 32 3410	M 3€ 6	8 Yrs.	Months Days	Hours Min.	Feb. 2	4,1935	PA	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limit	s
	Many	ţō	MD Balti	more		Esse	ex			1 □ Yes 2 N	
	th the or 282	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	hat Country?	_
	s 23a	rai	606 Riverside			21221			USA		
36	hours after death with the Maryland tural; or Items 23a or 28a-f show Exactiner must be rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 ☑ © vorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 🎎 No	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. White	
2-0	72 hours natural',	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occupation	on	vina	16b. Kind of Bus	iness/Industry	_
21215-0036	d within 72 ho piene. r than "natur ine Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	eptionist		"ig	Resc	co cicalS _{upply}	
d 2	Hyg Hyg ant,	e Co	12th 17. Father's Name (First, Middle, Last)		Nece			e (First, Middle.	Maiden Sumame		
Maryland	Q 22 D	To B	Francis Oswalo	d			Sarah			,	
lary	2 should and Men is marks surnatic		19a. Informant's Name/Relationship (Ty	•	19b. Mailir	ng Address (Street and			r, City or Town, S	tate, Zip Code)	_
	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		Elizabeth Schen 20a. Method of Disposition		606	Riverside	e Road	Baltin			
nor	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 Stremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crer	natory or other place) Crematory		1	Baltimo	city or Town, State	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License			. Name and Address	of Facility Co	nnellv	Funeral	HomeofEsse	ζ
Н			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dec	ath Do not ent	er the mode of dying, s	such as cardiac	or respiratory ari	rest,	Approximate Interval Between	_
	Physician		Immediate Cause (Final disease or condition	LUNG						Onset and Death	
H	/Medical Examiner		resulting in death)	Due to (or as a conse							_
	秦 淡	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse						I MONTH	
	cuted nd ransit	Examiner	that initiated events								
30,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a conse	equence of):						
8760,	icate b physic s the b	dlcal		l							_
Вох 6	death certific e attending p d for use as I	n/Me	IF FEMALE: 23b. Was decedent pregnant 2.	3c. If yes, outcome of pregr					23d. Date	of delivery	
	0 0 0	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown		Ectopic pregnancy Other (specify)			Month		
P.O.	that the do	Phy	9 Unknown		and the second			00 - Did.			
Records,	The law requires that the ate has been signed by the bage 2 should be detached.	ted by	Part II. Other significant conditions con	imbuling to death but not re	satting in the ar	nderrying cause given i	n Paπ I.	TI.		ute to the cause of death? Probably 4 Unknown	1
al Rec		Completed						24a. Was a autops perform	sy prio	ere autopsy findings available or to completion of cause of ath? Yes 2 No	,
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	☐ ER/Outpatien	0.1		(Check only or	ence 6 □Other		
J Of		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			ow injury occurred		=
Sior	Attending ir death. ector: Afte by the fune	catlo	1 Natural 5 Pending 2 Accident Investigation	(Month, Bay Your)	Пуску		2 □ No				
Division	ital or Attend rs after death al Director: ,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At the building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Si City or Town	treet and Number n, State)	or Rural Route Number,	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only one) 2 Medical Exemin	sician: To the best of my kn ner: On the basis of examin and manner stated.	lowledge, death ation and/or inv	occurred at the time, oestigation, in my opinion	date and place, on, death occurr	and due to the coed at the time, d	ause(s) and mann ate and place, and	ner as stated. d due to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License nu		2	1 1	Month, Day, Year)	
	Ì		Ja (Umus		- 00.1 =	DGO S.	5034		1/30/2	004	
	V		30. Name and address of person who co			Print) SURNE HUSP.	TAL GAR	A, BA	ctimeno.	MD	
横	Sta	te	31. Date filed (Month, Day, Year)	22. Registrar's Sign	ature			- /			
	Registr	ar	EER 0 3 2004	Rie de	Lan	d.					

	State of Maryland / Department of Health and I Certificate of Death	-	giene Reg. No. 20	06 02819					
	1. Decedent's Name (First, Middle, Last)	2. Dete of De	eth	3. Time of Death					
Physician /Medical	Harriet Louise Kuczynski	Februa	ary 2, 20	Yeer 1004 12:50 PM					
Examiner	4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or L								
	Stella Maris Hospice Lutherv	ille	Balti	more					
Funeral Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Dete of Birt (Month, De DEC 22	y, Yeer) 2, 1925	9. Birthplace <i>(State or Foreign</i> Country) Maryland					
	Usual Residence of Decedent	DEG 22	., 1723	raryrand					
how how	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits					
e Ma tried ctor	Maryland Harford Forest Hill			1 □ Yes 2√ No					
or 28	10e. Street end Number 10f. Zip Code		10g. Citizen of Wh	nat Country?					
th w	944 Del Ray Drive 21050		USA						
D after death with the Mar or tems 23e or 28e-f s direct must be notified Funeral Director	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14 Mexican, Puerton U,S. 15 Mexican, Puerton U,S. 16 Mexican, Puerton U,S. 17 Mexican, Puerton U,S. 18 Mexican, Puerton U,S. 19 Mexican, Pu	oecify Yes or No	- 14. Race Black.	- American Indian, White, etc.					
So safe	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify:		Specify:	White					
OO2	3 A wildowed 4 LJ Divorced Year or Dates:								
I 21215-0020 ed within 72 hours af bygiene. The "netural", or the medical Examin, the Medical Examin Completed by F	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Busi	iness/Industry					
The state of the s	Elementary/Secondary (0-12) College (1-4or 5+)		Clothing	Company					
C Herita		o (Eint Middle	Maiden Sumame						
Maryland d 2 should be file the end Mental Hy 7 is marked othe traumatic event To Be (ine Hack		,					
Tyla d Men d Men market				W-1- 7- A- / 1					
Ma d 2 sl h en ris r traur		orest Hi		21050					
Healt Ther	20a. Method of Disposition 20b. Place of Disposition (Name of	Date		ity or Town, State					
Baltimore, Maryland 21215-0020 pamit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Pyglene. Important: If item 27 is marked other than 'netural', or items 23s or 28s-f show any injury or other traumetic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place)								
Iting the the thank		2-3-04	Baltimo	re, MD					
Ball Sarmi Mpor any Ir	21. Signature of Fureral Service Licensee 22. Name and Address of Facility Cremation Society	of MD,	Inc.						
_ 60.200	Edward A. Gregorchik 299 Frederick Road	d Balt	imore, M	D 21228					
	23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac shock, or heart failure. List only one cause on eech line.	or respiratory ar	rest,	Approximate Interval Between Onset and Death					
Physician // // // // // // // // // // // // //	Immediate Cause (Final			Oriset and Death					
Examiner	Immediate Cause (Final disease or condition a. RENAL CELL CANCER sesulting in death)	1							
* 50	Due to (or as a consequence of):			1					
axecuted and and rial-transit	b								
58760, icate be axecuted physician and s the burial-transit edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.								
68760, cate be axe physician e the bunal-	Cause (Disease or Injury c.								
587 Sicate Physicate sicate	Due to (or as a consequence of):								
P.O. Box 6 tut the daath certific by the attending p etached for use as Physician/Mer	d	**		1					
Bath agath lfor class		1							
hat the de by the detected detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ribute to the cause of deeth?					
IS, P. es that the es that the igned by be detacted by Ph.		1 1	/es 2 ∐ No 3	B ☐ Probably 4X Unknow					
If Records, P.O. Box 68760, The law requires that the death certificate be axecuted ate has been signed by the attending physician and paga 2 should be detached for use as the bunal-transit Completed by Physician/Medical Examir		24a. Was a	an autopsy	24b. Were autopsy findings					
cord: v require been sig should b		perfor	med?	available prior to completion of cause					
II Record The law requir sate has been s paga 2 should Completed		_		of deeth?					
Vital Relicion: The licion: The licion: The licector, paga		1 U Y		1 ☐ Yes 2 ☐ No					
Vital sician: Ti certificat director, p	25. Was case referred to medical examiner? Hospital: Hospital: Classical								
₹ § § § F	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho		ence 6 XOther						
Division or Attanding after death. Director: After d in by the fune ertification	1 Natural 5 Pending (Month, Dey Year) Injury Work?	Zod. Dosonbo n	ow injury occurred	•					
Divisio or Attandl after death Director: A I in by tha f	3 Suicide 6 Could not be 200 Place of Latine, At home from street feature of the	28f. Location (S	treet and Number	or Rural Route Number,					
in state in	4 Homicide determined building, etc. (Specify)	City or Tow	n, State)	,					
Hospital or Hospital or 24 hours afte Funeral Dir Ately filled in	29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated								
N 4 C E > 19	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, (Check only one) 13 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, on the basis of examination end/or investigation, in my opinion, death occur and manner stated.	red at the time, o	date and place, and	d due to the cause(s)					
dic dic	29b. Signature end title of centifier 29d. Discense number 29d. Discense								
o the Hospif vithin 24 hour o the Funer ompletely fill	29b. Signature end title orcentifier / 29c. License number		7/2/1016						
2 2 2 2 0		5	1 /-	7 ////					
To tha Ho within 24.1 To the Fu completel	D4372	S	2/-	2/04					
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)		2/-	2/04					
	D4372		093	2/04					

FEBRUARY 2, 2004

HARRIET KUCZYNSKI

	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006
Physician /Medical	1. Decedent's Name (First, Middle, Last) CROVER C Kelbaugh 2. Date of Death Month Day 2004 2:154n
Examiner Funeral Director	GROVER C Kelbaugh 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTINGE VAME L'CAL CLUTER 5. Social Security Number 215-05-3964 4c. County of Death N/A 4d. City, Town, or Location of Death N/A 4d. Country of Death N/A 4d. Country of Death N/A 5. Social Security Number And And And And And And And And And And
aryland ahow	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
with the Maryla or 28a-f ahor be notified at Director	10e. Street and Number 700 Wost 40th Street 10f. Zip Code 10g. Citizen of What Country?
or items 23 aminer must y Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
3 -	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working Plife. DQNQTuse retired) 16b. Kind of Business/Industry (Give kind of work done during most of working Plife. DQNQTuse retired) 17. Steel Manufacturer
2 should be filed within end Mentel Hygiene. Is marked other than aumatic event, tra. M. To Be Comp	8th 17. Father's Name (First, Middle, Last) Grover C. Kelbaugh 18. Mother's Name (First, Middle, Maiden Sumame) Esther Pearl Heavel
permit. Peges 1 and 2 should be filed within Department of Health end Mentel Hygiene. Important: If Item 27 is mented other than any injury or other traumatic event, the Monde. To Be Comp	19a. Informant's Name/Relationship (Type, Print) Lorraine E. Rozankowski /Sister 1606 Thetford Rd. Towson, MD 21286 20a. Method of Disposition 1\(\tilde{\text{D}}\)Burial 2 \(\text{Cremation}\) Cremetation 3 \(\text{Removal from State}\) 20b. Place of Disposition (Name of cemetery, crematory or other place) 1\(\tilde{\text{D}}\)Burial 2 \(\text{Cremation}\) Cremetation 5 \(\text{Other (Specify)}\) 21. Signators of Pine Al Serve Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home 1 Serve 1 Se
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
nding physician and use as the burial-trensit n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
ing raw requires that the ceant bering that has been signed by the ettending page 2 should be detached for use e.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown
The taw required that has been a page 2 should completed	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
nysician: his cartific il diractor,	25. Was case referred to medical examiner? 1
ne Hospital or Attending P no 24 hours after death. The Funeral Director: After the pletely filled in by the funeral edical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
the Hospital hin 24 hours the Funeral mpletely filled	29a. Certifier (Check only one) 127 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
withi Comments of Marketin Mar	29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 1-29-04 30. Imperand address of person who completed cause of deeth (Item 23a) (Type, Print) Sepan M Fox 10N Greene Street Battinine MA 21201
State	Separ M Fox 10N Greene Street Battimore MS 21201 31. Date filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylar	nd / Dep	artment o	of Health a of Death	and Me	ntal Hyg	giene eg. No. 2001	02822
Š	Physici /Medio	al	Decedent's Name (First, Middle, Last) Anna Marie Kanis Ana Marie Kanis 4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tov	wn, or Location of	J	Date of Dea Month	Day Yeer	3. Time of Death 1:45 P M h
	Examin Funeral Director	er	Franklin Square Ho 5. Social Security Number 6. Sex 216 09 5221		last birthday) Yrs.	If Under 1 Y	Roseda	ale 24 Hrs. 8.	Date of Birth (Month, Day ep. 10	Baltime (Year) 9. Bin	
b, Maryland 21215-0036 and 2 should be filed within 72 hours after deeth with the Maryland sellth and Mental Hygiene. m 27 is marked other than "naturel", or items 23e or 28e-1 show her traumatic event, the Medical Examinar must be notified at	Sa-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		ty, Town or L Essex						10d. Inside City Limits 1 ☐ Yes 2√∑ No
	123e or 2	ral Directo	1703 Middleborough				1221			USA	
	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent If Yes, specify 1 ☐ Yes 2 ③	t of Hispanic Dri Cuban, Mexicar No Specify:		y Yes or No- an, etc.)			
	Completed	15. Decedent's Educ (Specify only highest grade Etementary/Secondary (0-12)	cation completed) Cotlege (1-4or 5+)	(Give	dent's Usual O s kind of work of DO NOT use r memaker	lone during mos etired)	st of working		16b. Kind of Business Own Home	Industry	
	To Be Co	17. Father's Name (First, Middle, Last) Theodore Merling				Marg	garet 1	Bieger	Maiden Sumame)		
	and ls m		19a. Informant's Name/Relationship (Type Theodore Phillip Bo	oyer (Son)	7407	Chesap	eake Ro	.Balt	imore,	Md. 21220	
Baltimore,	Department of H Important: If ite any injury or ott		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State Sa	cemetery, cre cred H		Jesus I		2004	20c. Location · City or Baltimore,	
Rail	Depart Import any in		21. Signature of Funeral Service License	wikowske		1407 C		ern A	venue]	Essex, Md.	21221
Physician /Medical Examiner		ner	23a. Ped 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter or deriving Cause (Disease or injury)	Sepsis Due to (or as a consecutor) Due to (or as a consecutor) Due to (or as a consecutor)	quence of): ct Infe		r dying, such as	cardiac or r	espiratory arr	est,	Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	physician and sthe burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. INcontinence Due to (or as a consequence of): Stroke							
	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3[⊒Ectopic pregr ⊒ Other (specif				23d. Date of del Month	ivery Day Year	
		Part II. Other significant conditions con						co use contribute to the cause of death? 2█No 3☐Probably 4☐Unknown			
		Completed								sy prior to death? 2 No 1 ☐ Yes	itopsy findings available completion of cause of 2 No
	this certif	To Be	1 195 25110	ospitat: 1 ☐ Inpatient	ER/Dutpatie		Dther: 4 🗆 Nu	ursing Home		ence 6 Other (Spe	cify)
	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28a. Date of Injury 28b. Time of 28c. Injury at Work? M 1 Per 2 No 28a. Date of Injury 4 Nome farm street factory office				No	28d. Describe how injury occurred				
DIVI: To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by			determined 286. Place of Injury - At norme, farm, street, factory, office 26. Loc					City or Town	ication (Street and Number or Rural Route Number, (ly or Town, State)		
1	in 24 ho the Fune pletely f	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.							to the cause(s)	
		Z	1 894354 Janua						nate signed (Month, Day, Year) nary 30, 2004		
	10		30. Name and address of person who con Stephanie R. Bruce	, MD. 5505 Ho	opkins		w Circle	e Balt	imore,	Md. 21224	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	bodi	•				

Registrar Certificate Of D	Death Reg. No. 2004 02823						
1. Decedent's Name (First, Middle, Last)	Date of Death Month Day Year						
Physician Urban E. Leimkuhler	January 26, 2004 4:00 P. M						
/Medical OFDSTI E. LETIRRUTTET 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or I							
3004 N. Ridge RD Apt. 202 Ellicot	t City Howard						
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country)						
Director 164-12-6695 12 M 2□F 82 Yrs. Months Days	10/10/1921 MD						
Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location	10d. Inside City Limits						
or sho	1 ☐ Yes 2 🛣 No						
MD Howard Ellicott City	y 10g. Citizen of What Country?						
3004 N. Ridge Road APT 202 2104							
3004 N. Ridge Road APT 202 2104 11. Marital Status 12. Was Decedent Ever in U.S. Amped Forces? 1 Nover Married 2 Married 1 Nover Married 2 Married 2 Married 1 Nover Married 2 Married 2 Married 1 Nover Married 2 Married 1 Nove	spanic Origin? (Specify Yes or No- 14. Race - American Indian,						
Amped Forces? If Yes, specify Cuban Married							
1 Yes 2 No Year or Dates:	Specify: Specify: White						
3 Swidowed 4 Divorced Year or Dates: 1 Yes 2 No 1 Ye	ation 16b. Kind of Business/Industry uring most of working State of MD						
(Specify only inighest grade completed) [ife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	and						
12 4 Civil Engineer							
17. Father's Name (First, Middle, Last) 9	18. Mother's Name (First, Middle, Maiden Surmame)						
P Ferdinand Leimkuhler	Louise Kimmel und Number or Rural Route Number, City or Town, State, Zip Code)						
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street as							
The state of Disposition (Name of	ve Ave. Baltimore, MD 21228 Date 20c. Location - City or Town, State						
20a. Method of Disposition 1	θ)						
*4 Donation 5 Other (Specify) Loudon Park Cemete 21. Signature of Funeral Service Licensee							
20a. Method of Disposition 1 \(\text{Surface} \) Buril 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) 1 \(\text{Disposition} \) 4 \(\text{Donation} \) 5 \(\text{Other (Specify)} \) 21. Signature of Funeral Service Licensee 22. Name and Address Sterling As 7.36 Edmonds	shton Schwab Funeral Home, Inc. son Ave. Baltimore, MD 21228						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	Interval between						
Physician Immediate Cause (Final disease or condition resulting in death) Amount of the condition of the co	Onset and Death						
Due to (or as a consequence of):							
Examiner Sequentially list conditions, b.	b. Cue to (or as a consequence of):						
any, isaling to winder							
Causé. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
on one of the control							
The first of the f	23d. Date of delivery						
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 9 Unknown 1 Cother significant conditions contributing to death but not resulting in the underlying cause give	Month Day Year						
of the poor of the							
	an in Part I. 23e. Did tobacco use contribute to the cause of death?						
w require been significant to the second to	1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown						
The law requires t gate has been signed page 2 should be Completed by	24a. Was an autopsy autopsy findings available prior to completion of cause of						
The is the interest of the int	performed? death? 1 ☐ Yes 2 ☑No 1 ☐ Yes 2 ☑ No						
	26. Place of Death (Check only one)						
	ar: 4 ☐ Nursing Home 5 № Residence 6 ☐ Other (Specify)						
25. Was case referred to medical examiner? 1 Yes 2 25. Was case referred to medical examiner.							
27. Manner of Death Section Sect	Yes 2 No						
- 200 a larm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
O THE	ne, date and place, and due to the cause(s) and manner as stated.						
29a Certifier 19 Certifying Physician: To the best of my knowledge death occurred at the time	the state of the state of the state and the state of the						
The second of th	pinion, death occurred at the time, date and place, and due to the cause(s)						
29a. Certifier Check only one) 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time of the control of the control one of the control o	e number 29d. Date signed (Month, Dey, Year)						
29a. Certifier Check only one) 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time of the control of the control one of the control o	e number 29d. Date signed (Month, Dey, Year)						
29a. Certifier Check only one) 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time of the control of the control one of the control o							

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and N State of Maryland / Department of Health and N State of ME,G829.3/31/04eg of Death	lental Hy	giene 2 Reg. No.	004	02824			
		Decedent's Name (First, Middle, Last)				Year	3. Time of Death			
Physician /Medical			LARRY SHANNON LEWIS	January	$y = 25^{ay}$,	20ď4°	0614 A.M			
1	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. Cou	inty of Death				
1			Washington County Hospital HAGERSTOWN		Was	shinata	ac			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bird (Month, Da	th	9. Birthpl	lace (State or Foreign try)			
	Director		217-38-3581 XXM 2 F 64 Yrs. Months Days Hours Min.	JAN. 16) WEST	VIRGINIA			
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			11	0d. Inside City Limits			
	aryla shov	-	10a. State 10b. County 10c. City, Town or Location			,	XXYes 2 □ No			
	8a-f	cto	MARYLAND WASHINGTON HAGERSTOWN		10.00					
	or 2	Director	10e. Street and Number 10f. Zip Code	1	-	of What Coun STATE	•			
	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	ra	350 SOUTH LOCUST STREET 21740		OF AME	RICA Race - America				
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married	Rican, etc.)		Black, White, e				
36	hours after tural', or ite al Exemine	by F	1 ☐ Never Married 2 ☐ Married		Spe	ecify:	PE			
2-0036	tural	pa	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind o	WHI]				
Ċ	filed within 72 Hygiene. Nher than "nai ont, Ine Woole	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	ring			,			
2121	with lene. the	E	Elementary/Secondary (0-12) College (1-4or 5+) 12th PLUMBER		PLUMB	ING				
ס ס	should be filed nd Mental Hygid marked other imatic event, I		17. Father's Name (First, Middle, Last) 18. Mother's Nam	e (First, Middle,	Maiden Sum	name)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
<u>a</u>	id be ental ked c	To Be	GARRETT HOBERT LEWIS EDITH MA	Y COX						
Maryland	should ind Men marks umatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur		er, City or To	wn, State, Zip	Code)			
	ath a		BILL LEWIS (BROTHER) P.O. BOX 656; PINEVIL	LE. WES	T VIRG	INIA 2	4874			
ē,	s 1 and 3 if Health item 27 other tra		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		on - City or To				
Ē	permit. Pages Department of Important: If it any injury or o	-	tXXBurial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) MORGAN CEMETERY 2004	- 1.	CENTER	VILLE.	wv			
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Price Licensee 22. Name and Address of Facility LOU	DON PARI	K FUNE	RAL HON	1E			
ñ	Ded Find		Man of amathy.	O WILKEI	NS AVEI MARYL	NUE AND 212	229			
			231. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.				Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition Pneumonia							
16.	/Medical		resulting in death) Due to (or as a consequence of):							
1	Examiner		Sequentially list conditions							
	~ ~	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	cuted nd transi	Examiner	Cause (Disease or injury that initiated events c.							
Ö,	icate be executed physician and s the burial-transit									
8760	ate b hysic the bi	dlcai	d							
9	ertific ling p	Mec	IF FEMALE:							
(G	ath co	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Festal death 3 □ Ectopic pregnancy			Date of delive Month	ry Day Year			
P.O. Box	the a	Physician/Me	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)							
٦.	that the death certificed by the attending properties as	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use c	ontribute to th	e cause of death?			
S	ires tha signed d be det	by	Hypertensive Atherosclerotic Cardiovascular Disease	Yes 2□No	2 No 3 Probably 4 QUnknown					
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transitions.		etec		040 1400	124	th Mass sute	nov findings available			
3ec	e law has je 2 s	Completed		24a. Was autor		prior to con death?	psy findings available appletion of cause of			
Vital Records, icien: The law requires the certificate has been signerector, page 2 should be d				1 Z Yes	2 No	1 🗷 Yes	2 No			
of Vital F Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Other: Other				no a see				
ō	Phys this ral di	10	1 inpatient 22 No 1 inpatient 22 No 4 Nursing Ho	ome 5 Resi			7			
no	Attending ir death. ector: After by the funer	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?		,					
2	or Attendate death Director: in by the	lica	3 Suicide 6 Could not be as Place of Injury At home farm street factory office	28f. Location (Street and Nu	ımber or Rura	l Route Number,			
Division of	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or To	wn, State)					
	Hospital 24 hours Funeral tely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time,	date and place	ce, and due to	the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number			gned (Month, I				
Shahal Acreber Mia							2004			
	1 gray		30. Name and address of parent of the state of the state (Item 23a) (Type, Print)	1						
	18		Tasha Z Greenberg 11 Penn Street	t, Balt:	imore,	Maryla	and 21201			
	Sta		31. Date filed (Month, Day, Year) 32. Registrat's Fignature							
	Regist	rar	31 Date filed (Month, Day, Year) 33 Registres ignature							
-	NALL 47 D. 4/0	004								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan	d / Depa	artment o	of Health a	and Me		giene Reg. No.	2004	028	25
			Decedent's Name (First, Middle, Last)		-			2. Date of Dea Month		Year	3. Time of Dea	ath
	Physicia /Medic		Audrey	Kathryn Luca	s				JAN.	29,	2004	7:30 p	М
)	Examin		4a. Facility Name (If not institution, give			1	own, or Location	of Death		4c.	County of Death		
			Crofton Convales				rofton Year If Under	24 Hrs.	0 5-1(5:4)			Arundel	
	Funeral		5. Social Security Number 6. Se 117-20-5680	х Эм 265 F 77	last birthday) Yrs.		Days Hours	Min.	8. Date of Birth (Month, Day FEB. 1	y, Year)	.926 Mary		reign
	Director	}	Usual Residence of Decedent	11					FED. I	<u> </u>	924 Mary	Tanu	
	yland Now	Ì	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					1	0d. Inside City L	
	a-f el	ctor	Maryland Anne	Arundel	(Crofton	า					1 ☐ Yes 2 X	_] No
	ith th	Directo	10e. Street and Number			10f. Zip C				10g. Citi	zen of What Cour	itry?	
	ath w	ra	2131 Davidsonvill		- 1		21114				USA		
	er de Itame	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑No	.S. 13.	Was Deceder If Yes, specify	nt of Hispanic Ori Cuban, Mexicar	igin / (Spec n, Puerto R	iry Yes or No- lican, etc.)		 14. Flace - America Black, White, 		
5	hours atter death with the Maryland tural; or Itams 23a or 28a-t ehow al Evaniner must be notified at	by F	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖸	No Specify:				Specify:	Mite	
5-0036	J within 72 hours after death with the Marylan jiene. Than "natural", or Itams 23a or 28a-f show tha Medical Examinat must be notified at		15. Decedent's Edi		16a. Dece	dent's Usual (Occupation done during mos	at of working		16b. Ki	nd of Business/Inc		
7	within 7 ene. than "n	ple	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use	retired)	st or working	9				
7	filed wi Hygien other th	Completed			Hor	nemakei		- 4- NI	/FT 4 # # 4 # 4	_	Domestic		
Maryland	at a d	Be	17. Father's Name (First, Middle, Last) Walter Nichol	son					(First, Middle, 3 Deard		Sumame)		
Ĕ	2 should t and Meni is marked	2	19a. Informant's Name/Relationship (T		19h Maili	ng Address //					r Town, State, Zip	Code)	
<u>8</u>	0 = 0		James M. Lucas/so								MD 21114	·	
ā,	s 1 and t Health item 27 other to		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name matory or other	of	Da			cation - City or To		
Ê	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3 C	Hemoval from State Mod			y, Inc.	1/30/	04	Ba	ltimore,	MD	
Baltimore,	in program		21. Signature of Funeral Service Licent	mc mil	් ලි	rematic	Address of Facility	ty of	Maryla	and.	Inc.		
n	Dep de de de de de de de de de de de de de		Dawn F. McDon		29	99 Fred	derick R	load	Baltime	ore.	MD 2122		
	看		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the deat one cause on each line.	h. Do not en	ter the mode of	of dying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	
-	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cach	ac t	trug to	Mich						
N.	/Medical Examiner		Tooding in doding	Due to (or as a consec	juence of):	1							
ä		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	juence of):								
	outed Id ansit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events	C									
o,	ate be executed thy sician and the burial-transit		resulting in death) Last	Due to (or as a consec	ruence of):								
8760	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	lical		d									
×	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancv						23d. Date of delive	10/	
Box	atten for u	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	death 3	☐Ectopic preg ☐ Other (spec				-	Month	Day Yea	r
o.	at the de by the a tached	nysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknown									
ري ت	signed by det	by Pi	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	ınderlying cau	ise given in Part I	l.	23e. Did to	obacco u	se contribute to th	ne cause of deat	h?
ecords,	w require been sig should b		Rueta	201		-			1 🗆 Y	/es 2[□No 3□Prob	ably 4 blnki	nown
ဝ၁	as be	Completed	General	Desily					24a. Was a		24b. Were auto	psy findings ava	ilable e of
r		Con		To the second se						rmed? 2∆ No	death? 1 🗌 Yes	2 🗆 No	_
Vital	nysician: The law nis certiticate has I I director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Othor		(Check only o				
	Phys this ral dir	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie 28b. Time of		c. Injury at		e 5 Resid		Other (Specify	()	
O	ding F th. After funera	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐				,		
Division of	Attendir death.	ifica	3 Suicide 6 Could not be determined		ome, farm, st	reet, factory, o	office	2:	8f. Location (S City or Tow		d Number or Rura	i Route Number	;
ā	tal or	Certification:	1 Tiornicide	building, sic. (Special	·y/				Only of Ton	m, otate,	, 		
,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification is completely filled in by the funeral director,	edical	(Check only / 2 Medicel Exem	ysician: To the best of my knowiner: On the basis of examina									
	o the ithin 2 o the o the complei	Med	29b. Signature and title of certifier	and manner stated.		29c. I	License number			29d. Dat	e signed (Month,	Day, Year)	
	- 3 - ŏ •		1			T	0570	28			1-30-1	24	
	N		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type	Print) 1	1 10.00	01, 10		0 11		101	
			HDITYA C	HOPRH, M	D W	UKIDG	CIVENCE	J. 13	1 Hnna	DOLS	SIMD:21	461	
	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 3 20	32 Registrár's Sign	ature	BASE	ę			•			

		•	For State Registrar	State of Maryland /	Department of Health and Certificate of Death		ene 2004	02826
	Physicia		1. Decedent's Name (First, Middle, Las H) LLER	EDWARD L	EACH	2. Date of Death Month	Day Year	3. Time of Death 2:53 PM
	/Medic Examin Funeral Director	er	1126 7726	street and number) HOS pita	Baltimore	8. Date of Birth		place (State or Foreign
	ryland thow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	1.3			10d. Inside City Limits 1 Yes 2 □ No
	the Ma 28a-f s	Director	10e. Street and Number	Ba 1	TIMOF C	100	g. Citizen of What Cou	
	th with		3516 (9-	ton Ave	21229		USA	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at or other traumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 100 If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify:	
15-0	in 72 ho "natur eoloni	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16	6b. Kind of Business/In	dustry
2121	filed within Hygiene. wher then "	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Bottler			16ch
Maryland	should be fit and Mental H is marked ott sumatic even	To Be	Benton Last	-each	Hes	me (First, Middle, Ma Tec S-	tewar	+ /
Mary	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address (Street and Number or R 112 Buck', ncham R	1 2 11	City or Town, State, Zip. Md. 212	_
Baltimore,	permit. Pages 1 and. Department of Health Important: If item 27 sny injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	of Disposition (Name of	Date 20	3altu-W	own, State
Balti	permit. Pag Department Important: I sny injury o		21. Signature of Funeral Service Vices		22. Name and Address of Facility Wester Charists 2007 Eastern Av	funera	1 Home	31
	1	X.	23a. Part1. Enter the disease, ocomshock, or heart failure. Lest only	plications that caused the death. Do one cause on each line.	not enter the mode of dying, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CARDISPU	1417	LIURE.		
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b. PULMONA Due to (or as a consequence	RY EMBOLIS			1 berry
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. ASPIRAT	ION PNEUMO	NIA.		3DAYS
68760,	ficate be executed physician and is the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a consequence	o of):			
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliv	ery Day Year
<u>α</u>	w requires that t been signed by should be deta		Part II. Other significant conditions of		in the underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to t	
of Vital Records,	: The law requipate has been page 2 should	Completed by	•			24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
Vita	Physician: rthis certifica ral director, i	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 k Inpatient 2 ☐ ER/C	Other	ath (Check only one)	ce 6 □Other (Speci	
ion of	Jing After fune	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	Time of Injury at Work? M 1 Yes 2 No	28d. Describe how		,,,
Division	at or Atter after de I Directo d in by th	ertific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
(To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of my knowled miner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and plac and/or investigation, in my opinion, death occ	e, and due to the cau urred at the time, date	ise(s) and manner as s e and place, and due t	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Pa Max	29c. License number		d. Date signed (Month,	
	8		PT fin C list	, M.D.	D002590	2 F	EB. 2ND	2054
	V			E, 4713 LEEDS	AVE, BALTIMO	RE M	0.212	27
Ī	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 3 20	32 Registrar's Signature	Agast 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 02827 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 5:15 РМ 31, 2004 Cecilia H. Langford January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Armacost Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day), Year) | Aug. 23, 1907 Birthplace (State or Foreign Country)
 Mary land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 KF 212-07-0694 96 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important; or itame 23a or 28e-f ehow important: If item 27 ie marked other than "natural", or itame 23a or 28e-f ehow any injury or other traumatic event, the Modical Examiner must be inclined as 1 Yes 2 No Completed by Funeral Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 USA 812 Regester Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filled within nent of Health and Mental Hygiene ant: If Item 27 ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Costume Designer Clothing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William E. Langford Rosie Britton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13808 Princess Anne Way; Phoenix, MD 21131 Anita Langford niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2/C Cremation 3 Removal from State 2/4/04 Baltimore, MD Western Cemetery * 4 ☐ Donation S ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athenes clewing Physician cardiovascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Tes To the Hospital or Attending Physician: Be 25. Was case referred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 🛮 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) K. Vump mien - 0 D31865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) street Balt: more Rm Cutow 206 31. Date filed (Month, Day, Year) 32. Register's Signature State FEB 0 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM #18 PER FH G828 2/03/04 JH Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 530 am -26-Vary 2004 ug /Medical 4b. City, Town, or Location of Death/ 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner pica Maris yere. 108 7 Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, ノー 3 ひ 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Min. Days Hours 1 M 25KF 3 Yrs. 60 5426 New 0-/ Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner nast be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 4.5. Lake or items 23a 904 20721 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 55 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Merital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer nent of Health end Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) sales Clerk 2 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LYNDA GRAHAM Cil 2 Lenoir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Department of Health e Important: if Item 27 is any Injury or other tra once. 904 Jather Laketront 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) hynden Kos Name and Address of Ficility 21. Signature of Funeral Service Licensee Cullot 01 Me 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each time. Approximate Intervat Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Cance Examiner Due to (or as a consequence of) Be Completed by Physician/Medical Examiner ettending physician end I for use es the bunal-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TU Yes 2 HNU 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Medical Certification: To 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manuar of Death 28b. Time of 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred After ! 1 Natural 5 Pending investigation death. 1 Tyes 2 □ No within 24 hours after death To tha Funeral Director: A completely filled in by the f 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) se bera 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 0 3 2004 **DHMH 16 Rev 6/95**

ORIGINAL

			For State	State of Maryla		rtment of H			211115	02829
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) KATHERINE 4a. Facility Name (If not institution, give s	M.		ERIN 4b. City, Town, or	G.	2. Date of Death Month	Dey Year	3. Time of Death
	Funeral Director		5. Social Security Number 578 10 0219 6. Sex	7. Age (In yr 1 M 280 F 89	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 1	N/A Year) 9. Birth Cou 1,1914 I11	plece (State or Foreign intry)
	D	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		City, Town or Loc Baltimor					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to C Health and Mental Hygiene. If item 27 Ia marked other than "natural", or items 23a or 28a-1 ahow or other traumatic avent. The Medical Exactions Livel Indiffical at	Funerai Director	10e. Street and Number 514 Wood Street 11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. W	10f. Zip Code 212 Vas Decedent of Hir Yes, specify Cubar			U.S.A. 14. Race - Ameri	can Indian,
9-0036	2 hours after atural, or ite	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	1 Yes 2X No If Yes, Give Year or Dates:	16a. Deced	Yes 212 No	Specify:	1	Specify: White Specify: White Specify: White Specify: White Specify: White Specify: White Specific Spe	ite
d 21215-0036	filed within 7. Hygiene. Ither than "n. ent. Ine Modi	e Compieted	(Specify only highest grade Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. D	kind of work done do NOT use retired) maker		ne (First, Middle, N	Own Home	
Maryland	2 should be and Mental I a marked o	To Be	George K 19a. Informant's Name/Relationship (Ty	oe, Print)		,			City or Town, State, Zi	
Baltimore, N	Pages 1 and 2 nent of Health int: If Item 27 iry or other tra		Katherine Knight 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	. Place of Dispos cemetery, crem	ood Stree sition (Name of latory or other place 1 Cemeter	9)	Date 2	Maryland 2 20c. Location - City or T Baltimore,	own, State
Balti	permit. Page Department (Important: If any injury or		21. Signature of Funeral Service License		le 40	Name and Addres	ie Highw	ge J. Gor ay Balti	nce Funeral More, Mary	Home, P.A.
8760,	trate be executed // Medical Examiner street burial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons Due to (or as a cons Due to (or as a cons Due to (or as a cons	⊭quence of∣:	VASCU	LAR	ACC	IDENT	Interval Between Onset and Death
.O. Box 6	the death certific y the attending p iched for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
ords, P	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions con	ntributing to death but not r	esulting in the un	derlying cause give	n in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to t	he cause of death?
tal Rec	The ate ha	e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was an autopsy perform 1 Yes 2	prior to co death? No 1 Yes	opsy findings available impletion of cause of
Division of Vital Records,	ding Phys Ther this funeral di	To B	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending Accident investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	^{IC} 4 □ Nursing H		nce 6 Other (Speci	(4)
Divis	in the se	i Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spe	cify)			City or Town,		
	To the Hospital within 24 hours a Yo the Funeral Completely filled	Medical	29a. Certifier (Check only one) 2 Medical Exami 29b. Signature and title of certifier	sician: To the best of my k ner: On the basis of exami and manner stated.	nation and/or inv	estigation, in my op	inion, death occu	rred at the time, da	use(s) and manner as site and place, and due to	o the cause(s)
)	T W I		30. Name and address of person who co	mpleted cause of death (II	em 23a) (Type, F	RES			S 130/3	, , , , ,
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 3 2004	32. Registrar's Sig	- Ba	Stimor	e MI	2122		

	For State Registrar		State of N	Marylan	d / Depa <i>Cer</i>	irtment <i>tificate</i>	of H	ealth ai Death	nd Mei		giene Reg. No.	2004	0283
Physician /Medical	ecedent's Name (Firs	t, Middle, Last)			LAS	NICK				Date of Dea Month NUARY	_	2004	3. Time of Death 7:20 P
Examiner	Fecility Name (If not in EWISH CONV	ALESANT	& NURS	ING HO		BAL	TIMO				ВА	County of Death	
Funeral Director	ociaf Security Number 20-05-2445	1 🗆	M 200F	Age (In yrs. I	35 Yrs.	ff Under Months	Days	If Under 2		Date of Birti (Month, Day)8/23/	1918	9. Birth	place (State or Foreig otry) MD.
ith the Maryland or 28e-1 show re nutilised at		County			y, Town or Lo	cation							10d. Inside City Limit
strain the Mar and the same of 280-1 strains and the must be must be another and the same of the same	Street and Number	DRIVE	2ND FLO	OR		10f. Zip 212				1	10g. Citiz USA	en of What Cou	ntry?
Ind 21215-0036 be filed within 72 hours after death with the Maryland tall Hylged with 72 hours after death with the Maryland of other than "natural", or items 23e or 28e-1 show event, the Medical Examiner must be notified at Be Completed by Funeral Director	Marital Status 1 □ Never Married 3 🛣 Widowed 4 □ I	2□ Married	2. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? No	1	Vas Deced Yes, spec	rfy Cubar	spanic Origi n, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- an, etc.)		4. Race - Ameri Black, White, Specify: WHI	etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "natural", or treumatic event, the Medical Exercit To Be Completed by F		Decedent's Educ ly highest grade (0-12)		or 5+)	16a. Deced (Give life. I SALESF	kind of wor OO NOT us	k done d e retired)	tion uring most o	of working		16b. Kin	nd of Business/Ir	ndustry
	Father's Name <i>(First,</i> DRRIS	Middle, Last)			WOLF			18. Mother		irst, Middle,		Sumame) PANEVIT	Z
re, Maryla s 1 and 2 should Health and Mer Item 27 is marke other treumatic	i. Informant's Name/F RS. SHIRLE		•	IN-LAW								Town, State, Zij 21215	p Code)
Baltimore, Me permit. Pages 1 and 2. Department of Health as Importent: If them 27 is eny injury or other treusure.	. Method of Disposition 1 □ Surial 2 □ Cre 4 □ Denation 5 □	mation 3 Re	emoval from Sta	20b. P	Place of Dispo	TSRAE	her pled	- 1)4	ROSE	DALE, MD	
Balt Permit Depart Import eny inj once.	Signature of Funeral	1 Fr	uger		89	00 RE	EISTE	RSTOW	N ROA	AD PIK	ESVI	BROS. LLE, MD	
Physician / /Medical	a. Part1. Enter the dis shock, or heart fail nediate Cause (Final ease or condition ulting in death)		MYO	sed the death	DIN	er the mode	of dying	g, such as c	ardiac or re	espiratory ar	rest,	MMC	Approximate Interval Between Onset and Death
8760, ate be executed thysician and the burial-transit alical Examiner	quentially fist conditionly, feading to immed to immed to immediate. Enter Underlying use (Disease or injury Linitiated events ulting in death) Last	ns, b		as a consequals as a consequals									
68760, ifficate be expression as the buriant ledical E		C _a											
P.O. Box 6: that the death certifice ed by the attending p detached for use as Physician/Mec	FEMALE: b. Was decedent pred in the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	trant	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Feta t at time of d	Ideath 3□	Ectopic pro Other <i>(sp</i> e					2	3d. Date of deliv Month	oery Day Year
ds, P. dires that the signed by id be detacted by Physical drives that the detacted by Physical drives are directly as a signed by Physical drives are dir	II. Other significant	conditions con	tributing to deat	h but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to		se contribute to	the cause of death?
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit; To Be Completed by Physician/Medical Examili;												24b. Were autoprior to codeath?	opsy findings availab ompletion of cause of 2 No
ding James fune	2 Accident	1	ospital: 1	njury Day Year)	ER/Outpatier 28b. Time o Injury	M 2	8c. Injury Work 1 🔲 Y	r: 4 Mur	sing Home 28d	d. Describe h	dence 6 now injury		,,
Divisic To the Hospitel or Attend within 24 hours after death to the Funeral Director: completely filled in by the 1 Medical Certificat	4 Homicide	determined		, etc. (Specif	(y)					City or Tox	vn, State)		al Route Number,
To the Hospitel within 24 hours a To the Funeral I completely filled Medical Ce	(Check only 2 one)	Certifying Phys Medical Examin	ner: On the basi and manner	s of examina	wledge, deati	vestigation,	in my op	inion, death	l place, and n occurred	at the time,	date and	place, and due t	to the cause(s)
Town Town	D. Signature and title Name and address of	1	mpleted cause	of death (Item	MC n 23a) (Type,		License	5/4	0.	1	JA	signed (Month,	, 2004
State Registrar	Date filed (Month, D	ay, Year)	41 MG 32. Reg	istrar's Signa	ature 6	200) /	KI	LE	The	H	Ist,	MP.7/3

		•	For State Registrar	State of Mar	yland		artment of He <i>rtificate of D</i>			iene 200	4 02831
	Dhursini		1. Decedent's Name (First, Middle, La						2. Date of Deal Month		3. Time of Death
	Physicia /Medic			VICE	LILL	IAN	LEVINSO		January	1 29 200	4 1920 PM
	Examin	er	4a. Facility Name (If not institution, giv	I I DIII.	more	,	4b. City, Town, or L	ocation of Death	,	4c. County of D	N/A
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. lasi				8. Date of Birth Month Day, DEC. 21,	Year) 9.	Birthplece (State or Foreign
E"	Director			□M 200 F	81	Yrs.	Miditals Duys	10013	DEC.21,	1922	MD
	/land		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, 1	Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	MD N/A			BAL	TIMORE				1 ∑ Yes 2 □ No
	in the	Dire	10e. Street and Number	AND COURT	"5		10f. Zip Code	01.000	1	0g. Citizen of What	
	eath v	Funeral Director	3020 FALLSTAFF I	MANUR COURT 12. Was Decedent Eve		13.	Was Decedent of His	21209	city Yes or No-	14. Race - A	U.S.A.
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural, or Items 23a or 28a-f show other traumatic event, the Madical Exeminal must be multiped at	by	1 Never Married 2 Married 3 🏋 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 1 No	Mexican, Puerto I Specify:	Rican, etc.)		/hite, etc. WHITE
ט ס	72 hc	Completed	15. Decedent's E (Specify only highest gra	ducation de completed)	1	(Give	dent's Usual Occupat kind of work done du	ion iring most of working	ng	16b. Kind of Busine	ss/Industry
7	within ene. then	June	Elementary/Secondary (0-12)	College (1-4or 5+)			DO NOT use retired) ESLADY			MEN'S CL	OTHING
<u> </u>	Hygi other	Be Co	17. Father's Name (First, Middle, Last	1		07.12		18. Mother's Name	(First, Middle, I		
<u>a</u>	should be filed with nd Mental Hygiene marked other than imatic event, he in	To E	ELLIS		k	COHNE		GERTRU	DE		LEVY
Z	h and h and 7 is m traum		19a. Informant's Name/Relationship (BILL LEVINSOHN	**			ng Address (Street ar SHENANDOA				, ,
Ď	Health tem 27 other tr		20a. Method of Disposition		20b. Plac	e of Dispo	osition (Name of	D		20c. Location - City	
<u> </u>	Pages nent of ant: If it ary or o		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special			-	matory`or other place, E HEBREW (1	2004	REISTERS	TOWN, MD
ם	permit. Pages Department of Important; If i any injury or once.		21. Signature of Foreral Service Lice	1. Cette	h		2. Name and Address 8900 REIST			SON & BRO PIKESVILL	S., INC. E, MD 21208
	r eggs		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death.	Do not en	ter the mode of dying,	such as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Hepa	tic	enc	ephaloj	Dathy			5 days
	/Medical Examiner		1	Due to (or as a c	consequer	nce of):	[/			/
h		Jer	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	consequer	nce of):					
	acuted ind transit	ami	Cause (Disease or injury that initiated events resulting in death) Last	c							
9/00,	icate be executed physician and s the burial-transit	edicai Examiner	resulting in death) cast	Due to (or as a o	consequer	nce of):					
000	ficate g phys	edic		_ d							
O. DOX	The law requires that the death certifute has been signed by the attending to has been signed by the attending bage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin	Fetal de	ath 3[□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
7	is that gned b	by Pf	Part II. Other significant conditions	contributing to death but	not resulti	ng in the u	inderlying cause giver	in Part I.	23e. Did tol	bacco use contribut	e to the cause of death?
cords	equire sen sig ould b		Cirrhosis, B	east Can	cer,	Hy	pertens,	on,	1 🗆 Ye	es 2 □ No 3 □	Probably 4 Honknown
2	a law r has be e 2 sh	Completed	Diabetes, P	ecurrent	A5	cite	5		24a. Was a autops perforr	sy prior	autopsy findings available completion of cause of
ומו	n: The ficate r, pag	e Cor	OF Man area referred to medical						1 ☐ Yes	2 1 0 1 0 Y	
5	ysicia s certi directo	0	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 (2)Inpatient	2□EF	VOutpatie	Other	26. Place of Death	A	ence 6 □Other (5	Specify)
5	ng Phy Iter thi neral	T :uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28	3b. Time o	f 28c. Injury a			ow injury occurred	,
DIVISION	tendii Jeath. tor: A the tu	cati	2 Accident investigatio			- 4		es 2 No	204 1 222122 /01	Annual and Mountains	Cont Contact Name
<u>≥</u>	after (Certification:	4 ☐ Homicide determined	28e. Place of Injury building, etc.		e, rarm, st	reet, ractory, office		City or Town		Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s	dical	29a. Certifier 1 Certifying Pl (Check only one)	nysician: To the best of experience on the basis of experience and manner state	xamination	edge, deat n and/or in	h occurred at the time evestigation, in my opi	a, date and place, a nion, death occurre	and due to the ca	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier	-1 . 1 1			29c. License		2	9d. Date signed (M	onth, Dey, Year)
	σ .		any	MUI			RE	5000		January	29 2004
	10		N. V. I	completed cause of dea	th (Item 2	3	Print) i Hospita	1 of B	altimo	1	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's	s Signatur	Θ _	11-77-1		. / - 1	-	
8	Registr	ar	FEB 0 3 200	14 Mayras	J.	Sept.	ME				

			1 - For State Registrar	State of Maryla	nd / Dep		lealth and I	Mental Hygi	_	04	02832
			1. Decedent's Name (First, Middle, Las	it)				2. Date of Death Month	Day \	rear	3. Time of Death
	Physici: /Medic		Joseph R. Mei	nustik				January		004	2050 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	h	4c. County of	Death	
			Howard County	General Hos	pital	Columbi			Howar	d	
	Funeral		Social Security Number 6. S		s. last birthday	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	(ear)	9. Birthpla	ace (State or Foreign
	Director		123 11 0032	% ^{M 2□ F} 79	Yrs.	William Suyo		Mar.14,			**
	p ,		Usual Residence of Decedent 10a, State 10b, County	100 (City, Town or L	agation					d. Inside City Limits
	anyla ehov	_	10a. State 10b. County	100.0	Jily, TOWITOLL	ocation					1 □ Yes 2 □ No
	86-1	cto	MD Howard	<u> </u>	Colum						
	or 2	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh		ry?
	n 72 hours after death with the Maryland "natural, or Itams 23a or 28e-f ehow solcal Examiner must be notified at	ral	5029 Green Mou	T		21044			USA		
	la ma	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Race Black,	 America White, e 	
2	or l	by Fi	1 Never Married 2 Married	1 √Yes 2 No		1 ☐ Yes 2 💢 No	Specify:		Specify:	Whit	te
0030	hours atter tural', or its	d b	3 Widowed 4 Divorced	Year or Dates:	100 000						
	nat	Completed	15. Decedent's Ed (Specify only highest gra	lucation .de completed)	(Give	edent's Usual Occur e kind of work done DO NOT use retire	during most of wor	rking	6b. Kind of Busi	iness/ind	ustry
7	d within 72 giene. ir then "na ire Medic	μ	Elementary/Secondary (0-12)	College (1-4or 5+)					, ,	~	
N	Hed v		17. Father's Name (First, Middle, Last)	5+	Mana	gement A	nalyst	ne (First, Middle, Mi	ederal		V
	d of o	Be									
Š	should nd Mer marke imatic	P P	John Menustik	Tues Orient	40h M-11			rine Mike			
	s 1 and 2 sh I Health and Item 27 le m other treum		19a. Informant's Name/Relationship (•							
ຜົ	1 and Health Iem 2; other 1		20a. Method of Disposition		_	osition (Name of	Juist III	The second secon	Dc. Location - C		
E E	Pages nent of the int: If Ite		1 ☐ Burial 2 【Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specific		cemetery, cre	matory or other pla	^{ca)} 02/0	1/2004		*	
	permit. Pages Depertment of t Important: If Its any injury or o			u		ash. Cre	ematory	71,2005	daulei	, 140	4.
galt	permit Deper Impor Impor Eny in		21. Signature of Funeral Service Licer			2. Name and Addre	TAT i	tzke Fu	neral	Home	es. Inc.
_	⊈O E € ol		1.01 Um	~	5.	555 Twin	Knolls	Rd. Co.	lumbia	. Mc	3.21045
			23a. Part1. Enter the disease, or jorn shock, or heart failure. List of V	dications that caused the de- ne cause on each line.	ath. Do not er	iter the mode of dyir	ng, such as cardiac	or respiratory arres	t,	,	Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition			androvern					Onset and Death
	/Medical		resulting in death)	Due to (or as a conse							
1	Examiner		Cogunatially list conditions	n Type it.	Diatrite	nellitu	→				years
i, E		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ur as a conse							
	cuted nd ransi	Examiner	that initiated events	c. Trenal cr		unun				(Han
Š	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a conse	equence of):						
-	9 % 0	cal		d							
QQ	the death certificate by the attending physic Iched for use as the b	Physician/Med	le service								
ŏ n	n cer andir use	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		□Ectopic pregnanc			23d. Date	of deliver	•
מ	deat e attr id for	ICIa	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)	у		Monti	h [Day Year
j.	t the by th ache	hys	9 Unknown	9□ Unknown							
 T	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions of	-	sulting in the	underlying cause giv	ven in Part I.	23e. Did toba	cco use contrib	ute to the	e cause of death?
cords,	quire n sig uld b	D T	Hypertinsian	5				1 ☐ Yes	2 □ No 3	☐ Proba	ibly 4 Unknown
	w re	Completed						24a. Was an	24b. We	ere autop	sy findings available ipletion of cause of
T O	stcian: The law certificate has b irector, page 2 s	E C						autopsy	ed? de	ath?	
		e C	25. Was case referred to medical			,	26 Place of Doc	1 Yes 2		Yes 2	
5	Physician: r this certific ral director,	o Be	examiner?	Hospital: 1 ☐ Inpatient 2J	ZED/Outpatio	0.4	200	ath (Check only one) Iome 5 - Residen		(0	
0	Phys raldi	 -	27. Manner of Death	28a. Date of Injury	28b. Time			28d. Describe how			
0	ding h	ţ	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □No		, ,		
DIVISION	deal ctor y the	Certification;	3 Suicide 6 Could not b	e 200 Place of Injury At	home, farm, s	treet, factory, office		28f. Location (Stre	et and Number	or Rural	Route Number.
2	after after Dire	erti	4 Homicide	building, etc. (Spec	cify)	,,,		City or Town,	State)		
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After it completely filled in by the funera		29a. Certifier 12 Certifying Ph	nysicien: To the best of my ki	nowiedne des	th occurred at the ti-	me date and place	and due to the co-	sa/s) and man	nar as etc	ted
	24 h	Medical	(Check only 2 Medical Exer	niner: On the basis of examinand manner stated.	nation and/or i	nvestigation, in my	opinion, death occu	irred at the time, dat	e and place, an	d due to	the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed ('Month, D	Pay, Year)
	გ ლ გ ლ კ) (11	10		1174	1461				3 2004
	X,		Ja UL	Ame in	00-1		10/		2000100	,	- 00 1/
	1		30. Name and address of person who	Completed cause of death (Iti	ып 23a) (Турв (1) []	2 m2 1/2	mi.	210 41			63
		10	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	23117	V	, - //			
	Sta Registi		FFR 0 3 266	14 Marian	to do	RAFE					

			For State	State of Marylan	•			lealth a D <i>eath</i>	nd Me		6.	004	02833
			Registrar	*1	Cer	linca	le oi L	Jeani		Re 2. Date of Deatl	g. No.		3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Las	marlin	17					Month	Day	Year	
	/Medio		FUWARD U	MUKTIN.						punnon	1.5	300H	1:20 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of	Death		4c. Coun	ty of Death	
	ЩН		Dinai Hospital	of Baltin		15.1.	Bal	Him				NH	
	Funeral		5. Social Security Number 6. Se	X 7. Age (In yrs.		If Unde Months		If Under 2 Hours	Min.	B. Date of Birth Month, Day	Year)	9. Birth	place (State or Foreign
	Director		224-05-7836	7 - 90	Yrs.					00-C	10		NO
	pus *		Usual Residence of Decedent 10a, State 10b, County	10c. Ci	ty. Town or Lo	cation							10d. Inside City Limits
	eho	٦	MA		RO His	20 A	0						1 X Yes 2 □ No
	ith the Marylan or 28a-f ehow	ecte	MO NH		<u>Julii</u>	10	0			T 4	og. Citizen o	(140	/\
	vith t	i i	10e. Street and Number	No Pand		101. 2	ip Code	DAG		1	og. Cilizen o	7 What Cou	nuyr
	ath v	rai	2820 HIIDU	WE ROW			2	201	. 0 (0	7 17	u	Ж.	all feeting
	er de	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	was Dec f Yes, sp	ecify Cuba	ispanic Orig in, Mexican,	Puerto R	ify Yes or No- ican, etc.)	14. B	ace - Ameri ack, White,	etc.
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates:	1	I □ Yes	2 No	Specify:			Spec	ity: RI	Innu
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow the Madical Exertiner runt by mulified at	pe	15. Decedent's Ed		16a. Deced	lant's Lis	ual Occupa	ation			16b. Kind of	Business/In	rdustry
5	n 72	Completed	(Specify only highest gra	de completed)	(Give	kind of w	ork done d	during most	of working	9	TOD. TRITIC OF	003111033/11	loustry
212	withi ane. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)	TASI	IDN	NIOP	Da	ENIT		nsur	1000	- Indiretor
	Hygie Hygie ther ant,		17. Father's Name (First, Middle, Last)	2100	11101	1 NT	1400	18. Mother	's Name	First, Middle, N	faiden Sum	ame) (1	Introven
an	buld be filed with Mental Hygiene. arked other than atic event, the M	Be c	Folhland M	artin				/					31121101011)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiens. Importants if item 27 is marked other than "natural", or items 23a or 28a-1 ehov importants if item 27 is marked other than "natural", or items 23a or 28a-1 ehov any injury or other traumatic event, the Madical Exprimer has be notified at any injury or other traumatic event, the Madical Exprimer has be notified at any layer.	ဥ	19a. Informant's Name/Relationship (7	OU IIII	19h Mailin	n Addre	s (Street a	and Number	or Bural	Route Number,	City or Tow	n State Zir	n Code)
Ma	12 sho h and 7 is m		EDUNG MOR	Lin (Mife)	12874	7 /	1115	dolo	Pr	and B	040	1000	21207
	1 and 2 Health tem 27 other tra		20a. Method of Disposition	[20b.]	Place of Dispo	sition (N	ame of	MIC	Da	te ;	20c. Location	- City or T	own State
Baltimore,	Pages nent of I int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cren		other place	j ///	0 N	121	RAL	Lunger	100 M
Ë	Pa ant ury		* 4 □ Donation 5 □ Other (Specify		eenmoi	int (rema		47C	0-04	Dui	FITTIO	re, IND
3a	permit. Pa Departmer Important eny injury		21. Signature of Funeral Service Licen	S00	22	. Name	and Addres	ss of Fi cility	ME	gnnc	sire	ene t	uneralsize
	0 0 = 0 0		lillyhne	DW	<u> </u>	151	12011	to. N	41.	PICe,	Date		D 21229
			23a. Part1. Enter the disease, or comp shock, or heart falure. List only	plications that caused the deal one cause on each line.	th. Do not ente	er the mo	de of dying	g, such as c	ardiac or	respiratory arre	est,		Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition	hunt	MOIM	. 14	1PAR	CTIGN					Onset and Death
	/Medical		resulting in death)	Due to (or as a consec									
	Examiner		Sequentially list conditions,	b									
	D =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):								
	cute nd rans	Examiner	that initiated events	c									
o,	an a	Ä	resulting in death) Last	Due to (or as a consec	quence of):								
8760,	cate be executed physician and the burial-transit	dlcai		d									
9	tifica ng ph as th	Ped											
Вох	andir use	5	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Tectopia	pregnancy				23d. D	ate of deliv	егу
	that the death certific ed by the attending p detached for use as	icia	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at time of o		Other (N	Aonth	Day Year
P.0	t the by th ache	hys	9 🗌 Unknown	9□ Unknown						Y			
	requires that the een signed by th nould be detache	Completed by Physician/Me	Part II. Dther significant conditions c	ontributing to death but not res	sulting in the ur	nderlying	cause give	en in Part I.		23e. Did tob	acco use co	ntribute to t	the cause of death?
Records,	quire n sig ald blu	D D	COPD							1 ☐ Ye	s 2□No	3 🗌 Prol	bably 4 Donknown
9	~ Q 70	iete								24a. Was ar	24t	. Were auto	opsy findings available
Re	9 4 9	m							_	autops	red?_	prior to co	ompletion of cause of
a	ician: Th certificate rector, pag	Ö	25. Was case referred to medical						10		No	1 🗌 Yes	2 1 No
Vital	Physician: this certific ral director,	m	exammer?	Hospital:	Seaso		Othe	er		(Check only on			
of	Phys this ral di	To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 2	ER/Outpatien 28b. Time of		JUA	4 U Nur		e 5 Reside			fy)
n	ding After fune	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	М	28c. Injury Work	k? Yes 2 □ N				41100	
Division of	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be		nome farm etc					of Location (St	reet and Nur	pher or Pur	al Route Number,
Ì	or A after Direct in by	rtit	4 Homicide determined	building, etc. (Speci	ity)	ooi, racio	ry, onlo			City or Town		11001 (11710)	ai i i outo i vaimbai,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	valciant Ta the heat of our to	outodas desir		d at the	no describ	l elect	ad due to the			
	Hos 14 ho Fun Fun tely f	edical	(Check only 2 Medical Exam	ysician: To the best of my knowner: On the basis of examination	owledge, death ation and/or inv	n occurre vestigatio	d at the time on, in my of	ne, date and pinion, deatl	i piace, ar n occurre	nd due to the ca d at the time, da	iuse(s) and r ite and place	nanner as s e, and due t	stated. to the cause(s)
•	thin the mple	Med	one) 29b. Signature and title of certifier	and manner stated.		2	9c. License	a number		20	d. Date sign	ned (Month	Day Yearl
	Z 18 5		M M						'n				
	1		1UD				y OC	2723	U		ANU IK	y 26,	1000 Y
	6		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)			\bigcirc	Mucho			
			FRED B JUNU	10 V G W, 223	W. Ker	n aD	our j	AUT,	15 h	MMOLT	, MD	812	/)
	Sta	ate	31. Date filed (Month, Day, Year)	Registrar's Sign	ature .	All I							

DHMH 17 Rev 1/2001

Edward Martin

			For State Registrar	State of	Marylar			nt of H		and M	lental Hy	giene Reg. No.	200	Britanin a	02834
	Dhysiai		1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea Month	ath Day	Yea		3. Time of Death
	Physici /Medic		Ernestine	L	Moc	ore					1	26	04		41308 M
	Examin	er	4a. Fecility Name (If not institution, give						Location o	of Death			County of De		
			Howard County 5. Social Security Number 6. S			pitl last birthday)		olum ler 1 Year		24 Hrs.	8. Date of Birt		lowar		O e (State or Foreign
	Funeral Director				67	Yrs.	Month		Hours	Min.	10-16	y, Year) -36	1 (CKY	MountNC
			Usual Residence of Decedent				1		1						
	nylan ihow		10a. State 10b. County		10c. Cil	ty, Town or Lo	cation							10d.	Inside City Limits
	death with the Maryland ma 23a or 28a-f ehow rmust be notified at	Director	Md Howard	d	J	Tessup									1 XYes 2 □ No
	vith th	Dire	10e. Street and Number					Zip Code	_				zen of What	Country	7
	a 23s	rai	8733 Mission	Rd.	not Ever in 11	12		2079		nin? /Sn	acify Vac or No.		JSA 4. Race - Ar	nerican	Indian
	ter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Force	es?				in, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		Black, Wi	nite, etc	
ğ	urs a	þ	3 XWidowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	X es:		1 🗆 Yes	5 X No	Specify:				Specify:	ВІа	ck
5-0036	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "natural", or Itema 23a or 28a-f ehow event, the Medical Esactinar must be notified at	Completed	15. Decedent's Ec (Specify only highest gra			16a. Dece	kind of	vork done o	durina most	t of work	ina	16b. Kir	nd of Busines	s/Indus	itry
2121	of thin	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT	use retired	1)				70 0 1		7 0 .
2	filed within Hygiene. Ather then ont, it a Me		12	4		1 1	'eac	her	19 Mothe	v's Name	e (First, Middle,			100	1 System
and		Be	17. Father's Name (First, Middle, Last)		0									w o w	0.0
Maryland	should be and Mental s marked o umatic eve	5	Robert 19a. Informant's Name/Relationship (Lawrenc	е	19h Maili	na Addre	iss (Street a		nnie	e Mee		Law:		
<u>8</u>	0 0 = 0		Donnell Porte	** '					on R		Jessup				
ē,	s 1 and f Health item 27 other to		20a. Method of Disposition	J1 (D)	20b. F	Place of Dispo	sition /	lame of			Date		cation - City		
ê	0 0		1 Donation 5 Other (Specific		ate (thsen				-1-(04	Edge	comb	s - C	o. N.C.
altimore,	글 된 원 분 .	- 3	21. Signature of Funeral Service Licer	isee	,	and the second second second					h				0. 1
ñ	Depa Impo eny ii		Lloyd M. Es	Celep		Ī	<u> 300</u>	Eut	aw P	lace	Funera e,Balt	imoi	e,Md	. 2	1217
	Physician / Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	as a consec	quence of):	an	CET	9, 33411 43					In	pproximate terval Between nset and Death
. Box 68760,	ath certific attending p for use as	Physician/Medical	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No		h 2∏Feta it at time of c	al death 3	∃Ectopic ∃ Other	pregnancy (specify)	,			2	3d. Date of c	lelivery Da	ıy Yəar
о. О	at the de d by the a stached	Phys	9 🗆 Unknown			n:			1 0 1		DZ- Dida				
Ś	res tha	by	Part II. Other significant conditions of	ontributing to deal	th but not res	sulting in the u	nderlyin	g cause give	en in Part I.			obacco u Yes 2[rotne o	cause of death?
0.0	w requir been si should	eted		-							4				
al Records,		Completed									24a. Was autop perfo 1 Yes		24b. Were prior to death	comp	r findings available letion of cause of No
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	- 0	Maria		Oth	or		n (Check only o				
o	Phys rthis sral di	To To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of (Month,		₽/Outpatier 28b. Time o		28c. Injun Worl	4 🗆 190		me 5 Residence 128d. Describe to			овсту)	
0	iding Phy th. : After thi funeral o	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М		k? Yes 2 □ l	No					
Division of	or Attencater death Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of	f Injury - At h	ome, farm, sti fy)	reet, fact	ory, office			28f. Location (S City or Tox			Rural R	oute Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical C	29a. Certifier tage Certifying Ph (Check only one) 2 Medical Exam	ysician: To the b niner: On the bas and manne	is of examina										
	withir To th	Me	29b. Signature and little of certifier				1	29c. License	e number			29d. Date	signed (Mo	nth, Da	y, Year)
) ATT	m				DS	5116	9			1/25	30	Y
	7		30. Name and address of person who	coppleted cause	of death (Ite		Print)	2.1	11 ^						
			Konni Bringma	in, MD	49	101 MI	tch	ellu	No R	d #	=102	150	Wire	m	D 20716
	Sta Registi		31. Date filed (Month, Day, Year)	32. Rec	jistrar's Sign	ature	2								

Registrar

FEB 0 3 2004

mark!

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 30, 2004 **Physician** Seatrice Irenido Corricte 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Linthicum Anne Arundel Hospice of the Chesapeake 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) June 20, 1921 Penna 6. Sex Birthplace (State or Foreign _ Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 82 182-16-0995 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at Maryland Anne Arundel 1 ☐ Yes 2 1 No Pasadena Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? death with 1312 Thomas Road 21122 USA 'natural', or Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or lient any injury or other treumatic event, the Medical Exemplement 2008. Black. White, etc. 1 ☐ Yes 2V No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Completed by Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Misty Harbor & Elementary/Secondary (0-12) College (1-4or 5+) 9 Seamstress London Foa 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Hildebrand Clara Bierley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Rader (Daughter) 1312 Thomas Road, Pasadena, Md. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem Pk Glen Burnie, Maryland ⁴ □ Donation 5 □ Other (Specify) 2/3/04 21. Signature of Funeral Service Licensee Revin E Ecker McCully-Polyniak Funeral Home, P 237 E. Patapsco Ave., Balto., Md 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician eneutic 3 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. physician Completed by Physiclan/Medical thθ as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Hinknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Atenoscientre Utswar Break 3 Probably 4 Junknown 1 ☐ Yes 2 ☐ No peeu Atrial Ribrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has rector, page 2 He porchoid 1 ☐ Yes 2 -NO or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death Check on one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 ⊒Natural 5 Pending s after death.
I Director: A in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Delli to the Hospitel 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hours To the Fune completely fi 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) au colin i cearl D19667 02-02-2004 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FFR 0 3 2004

			1 - For State of Maryla	•	artment rtificate			ind M		Reg. N	-2110	Company of the compan	028	38
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Robert James	Morga					2. Date of De Month Jan	30	2004		3. Time of De	eath M
	Examir	ner	4a. Fecility Name (If not institution, give street and number) 331 Homberg Ave.		4b. City, 1	E	SSEX If Under 2		O. Contr. of Bir		c. County of D	imc		
Ĺ	Funeral Director		5. Social Security Number 215-16-1874 Cusuel Residence of Decedent 6. Sex 15€ M 2 □ F 8. Sex 7. Age (In yrs	3 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Oct. 2	19, Year 4, 1	920 M		oce (State or F ry) Land	oreign
	e Maryland ta-f show	ctor	MD Baltimore 10c. C	ity, Town or Lo	cation	Ess	sex					100	d. Inside City I	
	th with th	Funeral Director	10e. Street and Number 331 Homberg AVE.		10f. Zip		21221	1		10g. C	itizen of Wha	t Countr	ry?	
9036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show to M. Jilgal Examilier must be notified at	by	11. Marital Status 1 Never Married 2 Marned 1 Never Married 2 Marned 3 Nover Married 4 Divorced 12. Was Decedent Ever in the Armed Forces? 1 Nover Married 2 Marned If Yes, Give Year or Dates:		Was Decedi f Yes, speci 1 Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto	ecify Yes or No Rican, etc.))-	14. Race - / Black, V Specify: W	Vhite, et	tc.	
21215-0036	filed within 72 ha Hygiene. other than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	16a Deced (Give life. L Plum	kind of work DO NOT use	l Occupa k done di e retired)	tion uring most	of workii	ng		Kind of Busine		•	
Maryland	Mental Mental arked atic ev	To Be C	17. Father's Name (First, Middle, Last) James A. Morgan				Sadi	ie P	(First, Middle,					
	and 2 sho ealth and n 27 is mu		19a. Informant's Name/Relationship (Type, Print) Sharon Schmidt/daughter						Route Numbel Balt				Code)	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once.		20a. Method of Disposition 20b.	Place of Dispo- cemetery, cren ollyHi	sition (Nam	e of her place)	D	ate 3 / 0 4	20c. l	ocation - City	or Tow		
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	1	300) Ma	ice A	ve.	nelly Balt:	imo	eralH re MD	ome 21	ofEss	ex
8760,	Physician and physician and physician and physician and physician and physician is the partial fluority.	Ical Examiner	23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consection of the consection of the consection of the cause). Due to (or as a consection of the consection of the cause). Due to (or as a consection of the cause).	quence of):	heros		*	5	r respiratory ai	rrest,		li li	Approximate Intervat Betwee Onset and Dea	en ith
.O. Box 6	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time of 9 □ Unknown	al death 3	Ectopic pre						23d. Date of Month	,	, day Yea	ır
rds, P.	w requires that been signed should be det	by	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying ca	use give	n in Part I.			obacco /es 2	_		cause of deat	
Il Records,		Completed							24a. Was autop perfo 1 Yes		orior	to comp	y findings ava pletion of caus	ilable e of
f Vital	Physician: Th r this certificate ral director, paç	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2] ER/Outpatien	t 3 🗆 DOA	Other	-		(Check only o		6 ☐Other (S	Specify)		
Division of	Attending Phideath. ctor: Atter thing the funeral		27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of Injury	M 28	ic. Injury Work?	-	2	8d. Describe h			, , ,		
Divi	or A	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At the building, etc. (Special Country of the building) and the building of the b	ify)				ļ	Bf. Location (S City or Tox	vn, Stat	в)			
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred a restigation, i	it the time in my opi	nion, death	l place, a n occurre	and due to the a	cause(s date an	and manner d place, and	as state due to th	ed. ne cause(s)	
	To t To t	Σ	29b. Signature and title of certifier		29c.	License	number	2	ī	29d. Da	ate signed (M	onth, Da	y, Year)	
	10		30. Name and address of person who completed cause of death (life To FF) 12 45 Eq. 5	0	Print)	jard	5100	550	× M	D	212	221		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sign		94E)									

			1 - For State Registrar	State of Marylan	•		of Health an of Death		Reg. No.	211016	02839
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Las A. Facility Name (If not institution, give	Nitchell	1:	4b. City, To	own, or Location of D	2. Date of I Month SANU-	Day AKU C	26 2004 County of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6. S	ENN NURSII ex 7. Age (In yrs. 63		ne If Under 1 Months		Min. 8. Date of I		Coun	lace (State or Foreign try)
	ie Maryland Ba-f show	ctor	10a. State 10b. County MD NA		y, Town or Lo						0d. Inside City Limits 1 Yes 2 □ No
	with the	Dire	10e. Street and Number 3051 Seamon A	venue		10f. Zip C	ode . 225			izen of What Coun S A	try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23e or 28e-f show may hiurry or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Opinorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	i		nt of Hispanic Origin Cuban, Mexican, F	? (Specify Yes or I Puerto Rican, etc.)		14. Race - Americ Black, White,	
Maryland 21215-0036	filed within 72 hc Hygiene. other than "natur ent, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th grade	ucation de completed) College (1-4or 5+) N/A	(Give life.	dent's Usual kind of work DO NOT use ood Se	done during most or retired)	f working		nd of Business/Ind 1timore	•
yland	should be file nd Mental Hy marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) Jessie Battle		T 401 14 11		Lu		a11		
	and 2 shr Balth and n 27 is m		19a. Informant's Name/Relationship (7) Tawanda Fores		3	ng Address (S Mainvi	Street and Number of	andallsto		0000	Code)
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 ary or other tra		20a. Method of Disposition 1 XBurial 2 Cremation 3 C 4 poqation 5 Other (Specify	Removal from State	Place of Disponentery, cremetery, cremetery	sition (Name natory or oth	of er place)	Date 72/2004	20c. Lo Lan	sdown, Mo	
Balti	permit. Departn Imports any inju		21. Sign ture 1 Funeral Service Licen 23a. Part 1 Enter the disease, or com	2 Kill	10			March Iabash Av	enue	West Balto, 1	Md 21215
8760,	rate be executed // Medicial and hysician and hysician and the burial-transit	licai Examiner	Immediate Gause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	a. Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq d.	uence of):	Br	east	Carci	non	nq	Onset and Death
P.O. Box 68	ath certific ttending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3□]Ectopic preg] Other <i>(spec</i>			-	23d. Date of delive Month	ry Day Year
	w requires that the de been signed by the a should be detached f	b	Part II. Other significent conditions c	ontributing to death but not res	ulting in the u	nderlying cau	se given in Part I.			se contribute to th	
al Records,	: The law recate has be	Completed							topsy rformed?	prior to con death?	osy findings available inpletion of cause of
of Vital	Physician: r this certificantal director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpatier	it 3 DOA	Tour of Code	Death (Check only ng Home 5 🗆 Re		E MOther /Specific	,1
ion of	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury		: Injury at Work?	28d. Describ)
Division	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: Afte completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, o	office		(Street and own, State	d Number or Rural)	Route Number,
	Hosp 24 hot Funa etely fi	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exan	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, deati ition and/or in	n occurred at vestigation, in	the time, date and p my opinion, death	place, and due to the control occurred at the time	e cause(s) e, date and	and manner as sta place, and due to	ated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier		- m n		icense number			e signed (Month, L	•
	,		Hmatan		210 N	DI	15503		JAI	NUARY	28,2004
	Sta Regist		30. Name and address of person who Amahun A 31. Date filed (Month, Day, Year) FFR 0 3 2004	NACCM 22. Registrar's Signa	m 23a) (Type,	Print) 50	Dolphi	NST E	BAI to	o, MD	28,2004

			1 - Stat Amend Item 29d, 3	State of Maryl Oper Dr.,G828,02	and / Dep 2/03/04dh	partment of	of Health and of Death	Mental Hy	/giene	02840
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of D Month	eath Day	3. Time of Death
	/Medio Examin Funeral Director		Patricia Burdi 4a. Facility Name (If not institution, give North August 1995) 5. Social Security Number 6. Social Security Number 1995 003-12-4713	e street and number) el HOSPH 7. Age (in)	r7 / yrs. last birthday 80 Yrs.	Glen y) If Under 1	wn, or Location of Dear	B. Date of B. (Month, D	4c. County	of Death ANUNDE 9. Birthplace (State or Foreign Country)
	ryland thow		Usual Residence of Decedent 10a. State 10b. County		. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the Ma 28a-f	Director	MD Anne Ar	undel (Glen Bu	rnie	nde		10g. Citizen of	
	th with 23a or	al Di	11 Leymar Road				21060		U.S.A	A .
5-0036	hours after death with the Maryland tural; or Items 23a or 28a-f show al Exatt, at must be indiffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2√7 No If Yes, Give A Year or Dates:	n U.S. 13	. Was Deceden If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i>	Specify Yes or N to Rican, etc.)	Blac	ce - American Indian, ck, White, etc. y: White
215-0	l within 72 ho liene. r then "natur tin Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Giv	. DO NOT use i	ione durina most of wo	rking		usiness/Industry
Ind 21	be filed wi	Be	17. Father's Name (First, Middle, Last)	Hoi	memaker			Own I	
Maryland	hould d Men marke matic	10	Roland Burditt 19a. Informant's Name/Relationship	Type Print)	19b Mai	iling Address (S	Natha treet and Number or R	Lie Cox	her City or Town.	State, Zip Code)
	nd 2 salth an 27 is trau		Mr. Malcolm McGre			eymar Ro			Ma ry1 ar	
altimore,	Pages 1 an nent of Heal int: # Item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	b. Place of Disp cemetery, cr	position (Name rematory or othe	of r place)	Date	20c. Location -	City or Town, State
Baltii	permit. Pa Departmen Important: any injury once.		21. Signal to of turn ral Service Lieu			22. Name and A	ddress of Facility Si	ingleton	Funera1	Home P.A. e, MD 21061
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)	onlications that caused the cone cause on each line.	death. Do not e	inter the mode o	f dying, such as cardia	c or respiratory	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	J.		b. Due to (or as a con	-mon	via				2day
	ate be executed hysician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Unno	189	trac	tinfe	Ain	ι	2 day
68760	cate be e physician s the buria	cal	(Demo	enfi'a	2				2 Jears
O. Box	death certif e attending id for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	B⊟Ectopic pregi i				te of delivery onth Day Year
ds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions	son		, ,	se given in Part I.	1		ribute to the cause of death? 3 Probably 4 Unknown
Records,	e la has	Completed	Bipo-6	lar disc	ord	ec	1	24a. Was auto perf 1 Yes	ormed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				~	ath (Check only	one)	
n of	ding Physician: h. After this certific funeral director,	on; To	1 ☐ Yes 27 No 27. Manner of Death 1. SNatural 5 ☐ Pending	Hospital: 1 Napatient : 28a. Date of Injury (Month, Day Yea	2 ER/Outpati 28b. Time Injury	of 28c.	Injury at Work?		how injury occur	
Division	or Attan ifter deal Director: in by the	Certification;	& Accident investigation 3 □ Suicide 6 □ Could not to 4 □ Homicide determined	99 Place of Injury	At home, farm, s	M street, factory, o	1 Yes 2 No		(Street and Numb own, State)	oer or Rural Route Number,
	To the Hospital within 24 hours a To the Funsral Completely filled	edical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, deanination and/or	ath occurred at t investigation, in	he time, date and plac my opinion, death occ	e, and due to the urred at the time	e cause(s) and ma , date and place,	anner as stated. and due to the cause(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier	Hending 1	thyeld	190 L	cense number D4497	3	29d. Date signed	d (Month, Day, Year)
			30. Name and address of person who Gurmeet S. Sawhney M.	completed cause of death of D., 325 Hospital	(Item 23a) (Type Drive #	202, Glen	Burnie, MD 2	1061	January	1375004
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	()	- A			

DHMH 17 Rev 1/2001

MCaregor

\$

		1 - For State Registrar	-	partment of Health and ertificate of Death	Reg. N	2001.02
Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of
Physicia /Medic		Elwood Beve	rly Miller		January	31 2004 6:02
Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	ath 74	c. County of Death
2.2		St. Agnes Hospit		Baltimore		
uneral Director		211-22-2770	x 7. Age (In yrs. last birthda XM 2□F 68 Yrs.	Months Days Hours Mir). (Month, Day, Yea	9. Birthplace (State of Country) Pennsylvan
*		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside C
f ehd	0	Maryland Howard	Elkr	idaa		1 ☐ Yes
288 E	Director	10e. Street and Number	LIAL	10f. Zip Code	10g C	Citizen of What Country?
Sa or		6372 Beechfield A	venue	21075	_	Jnited States
ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - American Indian,
in tream and well any species of them 23 and 28 and enow or other traumatic event, the Modical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 🔀 No Specify:	rto Rican, etc.)	Black, White, etc. Specify: White
atura cal E		15. Decedent's Edu	cation 16a. De	cedent's Usual Occupation	16b.	Kind of Business/Industry
Med.	Completed	(Specify only highest grad	e completed) (Gi life	ve kind of work done during most of w . DO NOT use retired)	orking	·····,
t a	E	12	Fue	el Truck Driver	Tr	ansportation
other vent, 1	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Maide	on Sumame)
rked c	To B	William Earl Mille	er	Lula Pe	earl Merica	
is ma	-	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Ma	iling Address (Street and Number or F	Rural Route Number, City	or Town, State, Zip Code)
em 27 is		Dave Twigg - Son	In Law 551'	7 Foxtail Lane E	llicott City	, Maryland 210
et e		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place)		Location - City or Town, State
nt: If		1 X Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)		dge Mem. Park 2/3	3/04 Elk	ridge, Maryland
Important: If its eny injury or o once.		21. Signature of Funeral Service Licens				
eny ii		Vand Bass	mo1378	22. Name and Address of Facility Sary L. Kaufman Fu 7250 Washington B	uneral Home Lyd Flkrid	At MMP., Inc.
- 1-1		23a. Part 1. Enter the disease, or compl	ications that caused the death. Do not e	enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate
		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	T 1111	0	Interval Bet Onset and I
sician ledical		disease or condition resulting in death)	Due to (or as a consequence of):	tony Failur	<u>C</u>	- 4 day
aminer			Due to (or as a cons— dence or).	NON COINE		1.100
W	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	TON COUNCE		1400
ansit	Examiner	Cause (Disease or injury that initiated events				
ial-tr	Exa	resulting in death) Last	Due to (or as a consequence of):			
sicia e bur	cal		1			
g phy as th						
ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery
d for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day
ache	hys	9 Unknown	9□ Unknown			
ned t	by P	Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of d
n signe	p p				1 ☐ Yes 2	Probably 4 □U
should should	Completed			-	24a. Was an	24b. Were autopsy findings a
ge 2	m				autopsy performed?	prior to completion of ca
certificate rector, pag	e Cc	25. Was case referred to modical			1□ Yes 2⊠N	o 1 Yes 2 No
is certificate ha director, page	ω	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	Chan	eath (Check only one)	
r this ral dii	. To	27. Manner of Death	1 ★ Inpatient 2 ☐ ER/Outpati	erit 3 DOA 4 Nursing	Home 5 Residence	
Atte	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury		200.200.000 11077 11110	y 55501150
irector n by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street a City or Town, Stat	nd Number or Rural Route Numbe)
To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, de	ath occurred at the time, date and place	e, and due to the cause(s	s) and manner as stated.
9 F	edical	one)	ner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	urred at the time, date an	id place, and due to the cause(s)
<u> </u>	Σ	29b. Signature and title of certifier	MA A COL	29c. License number		ate signed (Month, Day, Year)
To the complet			10100015111	0:017		
To the		Rachel TI	10 MIC SIVIL	P15627	Jan	4anu 31 200
To the		30. Name and address of person who co		9/5/6/2 / e. Print)	Jan	MD 2122

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1, Christopher George Newberger 4a. Fecility Name (If not institution, give street and number) February 2004 1:15 A /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Brightview Assisted Living Catonsville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex Days **Funeral** 1**∑**M 2□F Months Hours 87 16, 1916 Maryland Sept Director 215-07-5751 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yes 27 No Catonsville Maryland Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 2117 Oak Lodge Road 21228 death Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1√2 Yes 2 □ No 1/4 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Postal Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) rmit. Pages 1 and 2 should be fill partment of Health and Mental Hiportant: If Item 27 is marked oth y injury or other traumatic even Be Barbara Margaret Dittrich Joseph John Newberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Newberger - daughter 2117 Oak Lodge Road, Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If sny injury of 4 ☐ Donation 5 ☐ Other (Specify) 2/4/2004 Owings Mills, Maryland Garrison Forest 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Servicense 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acrtic Stenosis /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physiclan/Medical Examiner The law requires that the death certificate be executed the burial-transit Anemia and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physicien use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by d be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 certificate 1 Yes 2 No or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No this completely tilled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide To the Hospitel within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D57916 February 3, 2004 6-30. Name and address of person who completed cause of death (It in 23a) (Type, Print) 700 Geipe Road, Catonsville, Maryland 21228 Franz Sewchand, MD 31. Date filed (Month, Day, Year) FEB 0 3 2004 32. Registrar's Signature State Registrar

		1 - For Unpend Item #23	State of Ma a,pt.II,27	arylar per m	nd / Depa = G828-2	artmen 25/04 <i>tilic</i> at	t of H	ealth a D <i>eath</i>	and M	lentai Hy	giene Reg. No.	201) [021	340
Physic /Medi		Decedent's Name (First, Middle, Last	Mary Joa	n N	Nugent					2. Date of De Month Januar	Day	, 200	Year	3. Time of 12:01	
Exami		4a. Facility Name (If not institution, give 3735 Roland Avenu	e, Apartm			-	ltim	Location Ore			4c.	County o	Death	A	
Funeral Director		5. Social Security Number 6. Se 213-42-4694 15 Usual Residence of Decedent	X 7. Ag	59	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept 2	y, Year) 7,194	- 1	Coul	place (State of htry) yland	r Foreig
e Maryland a-f show	ctor	Maryland N/A		10c. Ci	ty, Town or Lo Balt	cation imore	9					-	1	0d. Inside C	•
ith with th	al Director	10e. Street and Number 3735 Roland Avenue	ė			10f. Zip	Code	212	11		10g. Citiz	en of Wh	USA	•	
a within 72 hours after death with the Maryland Jiene r than "natural", or Items 23a or 28a-f show L'is Medical Examirar must be notitied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Proceed	12. Was Decedent Armed Forces? 1 Yes 2 H If Yes, Give Year or Dates:			Was Deced f Yes, spec I ☐ Yes		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)			White,	an Indian, etc. hite	
within 72 ho ene. than "natur the Wedical I	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5	i+)	life. I	tent's Usua kind of wo DO NOT us	rk done d se retired,	luring mos)				d of Bus		,	
filed Hygi Sther	To Be Co	17. Father's Name (First, Middle, Last) Leonard Potts						18. Mothe	er's Name	(First, Middle, ine Rid		Sumame,			
and 2 sh ealth and n 27 ls m		19a. Informant's Name/Relationship (T) Cheryl Kierce	Daughter	-1	13 E1	kwood	l Cou		Cato	A Route Numbers	, Mai	ry1aı	nd 2	1228	
Pages nent of ent: If i		20a. Method of Disposition 1		0	Place of Dispo cemetery, cren odlawn	natory or o	ther place		2/2/2	2004			•	own, State arylar	ıd
permit. Departr Imports any inju		21. Signature of runeral Service (see see see see see see see see see s	arpente		· B	631 F	e-Her Palls	iss-S : Roa	eitz d	Funera Baltimo	re. N	ne, Mary	Inc. Land	21211	9
death certificate be executed Example and the purial transit and for use as the burial transit	Ilcal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as Due to (or as Due to (or as Due to (or as	a conseq	uence of):										
that the death certifics ed by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pro					20	3d. Date (•	'ear
sign d be	þ	Part II. Other significant conditions co Subdural hematoma	ntributing to death be	ut not res	ulting in the ur	derlying ca	ause give	n in Part I.						e cause of do	
The law ate has b page 2 sl	Completed									24a. Was autop perfor 12 Yes	sy	prid dea	or to con uth?	osy findings and pletion of ca	
ding Phys h. After this funeral dii	atlon: To Be	25. Was case referred to medical examiner? 1 [XYes 2 No Figure 1 No Figure 2	lospital: 1 Inpatie 28a. Date of Injur (Month, Day		ER/Outpatient 28b. Time of Injury		A Other	r: 4□Nu	rsing Hon	Check only on the 5 Resid	ence 6			at sc	ene
in Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc.	ıry - At he . (Specif	ome, farm, stre	et, factory	, office		2	8f. Location (S City or Tow	treet and n, State)	Number	or Rura	Route Numi	>e <i>r</i> ,
Hos Fur be	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred a estigation,	at the time in my opi	e, date and inion, deat	d place, a th occurre	and due to the o	ause(s) a date and p	nd mann lace, and	er as st	ated. the cause(s)	
To the within 2 To the complet	Σ	29b. Signature and title of certifier Ref Luw	lal A	10) ^	29c	License O.	number .C.M.	Ε.		^{29d. Date} Janu			2004	
12 boy		30. Name and address of person who co	+ AL	/	111		Stre	æt,	Balt	imore,	Mary.	land	212	:01	
Sta Registr	- 12	31. Date filed (Month, Day, Year)	32. Begistra	_		All I								-	

		For State Registrar	State of M		•	tificate					Reg. I	2	004	0284
Dhamini		1. Decedent's Name (First, Middle, Last,								2. Date of Month		ay	Yeer	3. Time of Deat
Physici /Medic		Margaret Anne O'D	ay							Janua			2004	11:15 A
Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location	of Death			4c. Co	unty of Death	
		Charlestown Retir						ille					1 ti mor	
Funeral		5. Social Security Number 6. Set	(7. Ag]M 2 2 ∫F	ge (in yrs. last b		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of (Month,	Birth <i>Day</i> , Yea	ar)	9. Birth	place (State or Fore ntry)
Director		3/8-30-0801	J.W. 423.	83	Yrs.					6/4/	<u> 1920</u>		MD	
* _	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation								10d. Inside City Lin
e e	5													1 Tes 2
98-1	ect	MD Baltimor	e		C	atons		.e			100	Citizon	of What Cou	otov?
ital Hygiene. svent, the Medical Examiner must be neithed at	Completed by Funeral Director	10e. Street and Number	-			TUT. ZIP		000			109.			may?
23s	ra	717 Maiden Choice		E - : 110	40			228	i=i=0 /C==	-4. V	No.		J.S.A.	see Indian
in team	nue	11. Marital Status	12. Was Decedent Armed Forces	?	13.	was Deced If Yes, spec	ent of Hi	n, Mexica	n, Puerto	cify Yes or Rican, etc.)	No-		Race - Ameri Black, White,	
高	Y	1 Never Married 2 Married 3 ✓ Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give	No		1 ☐ Yes 2	No No	Specify				Sp	ecify:	440
urer.	D D	•	Year or Dates:	1.0	- D	dent's Usua	1000000	tion			166	Vind (W I	nite
E S	lete	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	kind of wor DO NOT us	rk done d	during mos	st of worki	ng	100.	King	or business/ii	laustry
Para Para Para Para Para Para Para Para	ш	Elementary/Secondary (0-12)	College (1-4or	5+)				,				17		
Hygie other t		17. Father's Name (First, Middle, Last)	4		se	creta	ry	18 Moth	er's Name	(First, Midd	de Maid		nergy	
nd Mental Hygiene. marked other than imatic event, the M	Be												maine)	
and Mental s marked o sumatic eve	ဥ	Joseph J. Mack								h Jen				
_ <u>e</u> e e e		19a. Informant's Name/Relationship (T)	•										own, State, Zij	o Code)
n 27 n 27 ier tr		Kathleen O'Day -	Daugnter	- Indiana	-			Ka.		teek,				
Department of Health Importent: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place cemei	of Dispo ery, crei	nsition (Nan matory or o	ne of ther plac	e)	L	ate	20c.	Locati	ion - City or T	own, State
nent of l		*4 □ Donation 5 □ Other (Specify)	TOTAL TOTAL STATE	Balti	more	/Wash	ingt	on	2/3/2	2004	La	ure	1. MD	
artmen ortent: injury		21. Signature of Funeral Service Licens	ee 1 1	1										Catons=
Departr Departr Imports any inj		Semand	Tolora	estre)	\									sville, M
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that cause	d the death. De	o not ent	er the mod	e of dyin	g, such as	cardiac c	r respirator	y arrest,			Approximate Interval Between
nysician Medical xaminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as	s a consequence	e of).	irdi	on	ryo	put	hy				
ringstrient. The law requires that the geath centificate for executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	cal	resulting in death) Last	Due to (or as	a consequenc	e of):									
ding se as	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy								234	. Date of deliv	en/
y the atten	Physiclan/Med	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth	2 ☐ Fetal dea at time of death		∃Ectopic pr ∃ Other (sp					-	230	Month	Day Year
ed by deta	4	Part II. Other significant conditions co	ntributing to death I	but not resulting	in the u	nderlying c	ause giv	en in Part	1.	23e. D	id tobacc	o uśe	contribute to t	the cause of death
sign d be	d b	Thoracic Ao	rti An	Planus	m					1	□Yes	2 🗆 N	lo 3 Pro	bably 4 Donkno
been si should	Completed by	77.07200.	770 777	77						04-14		-[-	Ab. 18/	
s certificate has birector, page 2 s	du									24a. W	ras an Itopsy Erformed		prior to co death?	opsy findings availa empletion of cause
pag	ö									1□ Ye			1 Yes	2□ No
ctor,	Be	25. Was case referred to medical examiner?							e of Death	(Check on	ly one)			
this co	ို	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ient 2 ER/	Outpatie	nt 3 DC	Oth	er: 4 2 N	ursing Ho	me 5□R	esidence	6 [Other (Speci	fy)
After th	Ë	27. Manner of Death	28a. Date of Inj (Month, Da		. Time o	f 2	8c. Injun Wor	at k?		28d. Descrit	oe how in	ijury o	ccurred	
ath.	atle	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		, ,	М		Yes 2 ☐]No					
hours after death. Inerel Director: After y filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of in	njury - At home, atc. (Specify)	farm, st	reet, factory	, office				n (Street Town, St		lumber or Rur	al Route Number,
s afte	Ser		55	,-,-,,						,				
within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the besi iner: On the basis and manner s	of examination :	ge, deat and/or in	h occurred vestigation	at the tin , in my o	ne, date a pinion, de	nd place, ath occurr	and due to t ed at the tim	he cause ne, date a	(s) and	d manner as s ace, and due t	stated. to the cause(s)
omp thin	Me	29b. Signature and title of certifier				290	. Licens	e number			29d.	Date s	igned (Month,	Day, Year)
s ⊢ ū		1. 1.	1.	100	v.	7		277			,	1-	20/04	
\		Nenew Di	svem	1 mes	. ~		444	377				1 3	0104	
V		30. Name and address of person who c					, ,		100					
•		Deneen Bowlin mp	711 Maide	en Choi	coh	eine,	cate	INS NC	ile i	mo	2122	-8		
	te	31. Date filed (Month, Day, Year)	32. Regist	rars Signature		-01								
Sta Registi														

ORIGINAL

			For State Registrar	State of Maryland		irtment of Health and tificate of Death	Mental Hygie	6004	02845
			Decedent's Name (First, Middle	, Last)			2. Date of Death		3. Time of Death
	Physicia		Addie	Owens			Month	25 2004	8:56 PM
3	/Medic Examin		4a. Fecility Name (If not institution,			4b. City, Town, or Location of Deat		4c. County of Death	0.00
	Examin	EI	Hospital -	11 - 11 - 11	hal	Baltimore		11/	A
	Funeral		5. Social Security Number		st birthday)	If Under 1 Year If Under 24 Hrs		9. Birthp	lace (State or Foreign
	Director		218-01-4223	1□M 2风F	7 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye No V. 23,	19/6 50U	TH CAROLINA
7			Usual Residence of Decedent						
Š	how	.	10a. State 10b. County	10c. City,	Town or Lo	cation	1	1	0d. Inside City Limits
No.	- F	cto	MARYLAND	NA		BALTIMORE	CITY		1 ŻYes 2 ☐ No
4	or 28	Director	10e. Street and Number			10f. Zip Code		Citizen of What Cour	ntry?
ŧ.	23a	a	4105 PAS	SCAL AVE.		2/2	26	USA	-
200	S E	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of Hispanic Origin? (5 Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
1215-0036	ited with 72 mous and ocali, will the way has lited Hygiene. event, the Medical Exercit with the moult be notified at	F	1 Never Married 2 Marri			□Yes 2ŽNo Specify:		Specify: i/)	
21215-0036	le i	d by	3 Widowed 4 □ Divorced	Year or Dates:				100	LACK
2	nat a	Completed	15. Decedent (Specify only highes		(Give	lent's Usual Occupation kind of work done during most of wo	rking 16b	. Kind of Business/In	dustry
12	than	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	## E	OO NOT use retired)	1/50 5	10000 1101	1. MARTIN-P
CA A	Hygie ther 1		17. Father's Name (First, Middle, I	act)		ACTORY WOR	me (First, Middle, Maid		UFACTURER
anc ,	od of	Be	1-111-	<	101	2 /// // 6	O I I	E P.	1 = -1
Maryland	t and 2 should be t Health and Mental tiem 27 is marked other treumatic ev	٩	LLL/O//	in /Type Print)	10h Mailin	g Address (Street and Number or R	ural Pouta Number Ci	ty or Town State Zin	AK ION
Ma	h and 7 is r		1	. (0.	11 10		arar Houte Walliber, Cit	ly or rown, state, zip	21221
	of Health of Health item 27 i		ANNIEM. OWE 20a. Method of Disposition	70 700 11	ce of Dispos	Sition (Name of	Date 20c	Location - City or To	10.2/226 own, State
ğ	rages nent of f int: If it		1 Burial 2 ☐ Cremation	3 Likemoval from State		sition (Name of patory or other place)	49		
			*4 □ Donation 5 □ Other (Sp	19271	LTIMO	DRENATIONAL DO	02-04 15	ALTIMORE	
Balt	Depa Impo any ir		21. Signature of Funeral Service I	Icensee	22	Name and Address of Facility	BROWNUK	2. FUNER	
	10100		rence	complications that caused the death.	0 0	2140 N. FULTE	NAVEIX	SALTO, M	0 2/2/7 Approximate
			shock, or heart failure. List	only one cause on each line.	Do not ente	er the mode of dying, such as cardia	c or respiratory arrest,		Interval Between Onset and Death
,	hysician		Immediate Cause (Final disease or condition resulting in death)	- Myocard	10	Infaction			
	/Medical xaminer		resulting in death)	Due to (or as a consequent	ence of):	•			
	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_	Sequentially list conditions,	b. Ha De ten					
7	sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due total as a conseque	erice ory.				
100	and I-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequ	ance of):				
8760,	physician and the burial-transit	ai E							
.O. Box 68760,	physician the buria	dlcai		d					
9 ×	attending p	/Me	IF FEMALE:	23c. If yes, outcome of pregnan	cv			O2d Data of dollar	
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3□	Ectopic pregnancy Other (specify)		23d. Date of delive Month	Day Year
P.O.	the d	Physiclan/M	1 ☐ Yes 2 █ No 9 ☐ Unknown	9 Unknown	III 3L	Cittel (specify)			
و ۵	ed by the detached	۲	Part II. Other significant condition	ns contributing to death but not resul	ting in the ur	iderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
Records, P	signed d be dei	d by	Peripher	al Mascular	Dis	eose	1 ☐ Yes	2 No 3 Prob	ably 4 Lunknown
Ö	been s	ete	6, 1,	01000101			240 1460	04h 14/2-2 2-14	andiadiana mailable
3ec	has l	Completed	- stope				24a. Was an autopsy performed	prior to con	psy findings available impletion of cause of
<u> </u>							1 ⊠ Yes 2□		2 🗆 No
Division of Vital Records,	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	ath (Check only one)		
of	s o	٩	1 Yes 2 0	1 inpatient 2	R/Outpatien 28b. Time of	1 3 DOA 4 Nursing r	dome 5 ☐ Residence 28d. Describe how in		y)
חכ	a fa	io	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	20d. Describe flow in	njury occurred	
/ision	death.	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ot be Ope Blace of Injury At hor	ne form etr		28f Location (Street	t and Number or Rura	I Poute Number
ĭZ S	office of the parties	rţţ	4 Homicide determine	building, etc. (Specify)	ne, iaim, sue	eet, factory, office	City or Town, Si	tate)	i noute wantber,
	within 24 hours after deathing the within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral		29a. Certifier the Certifyin	g Physician: To the best of my know	ledge doot	occurred at the time, date and alex-	and due to the comme	a/s) and manages	ated
2 3	24 hc Fun stely	Medical	(Check only one)	g Physician: To the best of my know Examiner: On the basis of examinati and manner stated.	on and/or inv	restigation, in my opinion, death occ	urred at the time, date	o(s) and manner as st and place, and due to	the cause(s)
	ithin o the omple	Me	29b. Signature and title of certifier	and marries states.		29c. License number	29d.	Date signed (Month,	Day, Year)
	- ≯ - ŏ		▶ \ \ \ \ \ .	_ MD		053462		1/27/04	
C.1	3		30 Name and different of several		23a) (Tuna 1		seses m		
	9			who completed cause of death (Item	_ l _	MISUNNIC, MI		ن ر	
	Sta	to		2004 32 Registrar's Signal	ire OK	A COLVINE, WILL	- 4100	1	
	Registi		31. Date filed (Month, Day, Year)	2004					

			For State Registrar	State o	f Maryland / D	Depai <i>Cert</i>	rtment of H	ealth and Death	Mental Hy	giene	2004	02	846
	Physici		Decedent's Name (First, Mid Dougl	,,	er				2. Date of De Month Janua:	aath Dav	Approximately of the cause of t		
	/Medic Examin		4a. Facility Name (If not institution Gilchrist	ion, give street and num	n <i>ber)</i>		4b. City, Town, or			4c. (County of Death		
	Funeral Director		5. Social Security Number 212-26-8410	6. Sex 1)X() M 2 □ F	7. Age (In yrs. last birti 75		If Under 1 Year Months Days	If Under 24 Hi Hours Mii	1. (Month, D.	nth ay, Year) ∃r 16	9. Birth Cou , 1928	olace (State o ntry) Maryla	r Foreign and
	Maryland -f ehow ilog at	tor	Usual Residence of Decedent 10a. State 10b. Coun Md. Bal:	timore	10c. City, Town								
	with the	i Director	10e. Street and Number 11 Hammen A		7 2.110		10f. Zip Code			10g. Citiz			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Dece Armed Fo	2 No				Specify Yes or Norto Rican, etc.)		4. Race - Ameri Black, White,	can Indian, etc.	
Baltimore, Maryland 21215-0036	od within 72 ho giene. er then "natu , the Medical	Completed		ent's Education lest grade completed) College (1	-4or 5+)	(Give kil	nt's Usual Occupa nd of work done of NOT use retired, Enginee	uring most of w	orking				
aryland	should be file nd Mental Hy marked oth imatic event	To Be (17. Father's Name (First, Middle T. Milton 01 19a. Informant's Name/Relation	er	19b.	Mailing	Address (Street a	Myra	ame (First, Middle Hayes Bural Boute Numb			Code	
nore, Ma	ages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 27 ls or other trau	ļ	Mrs. Leah Jo 0 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation	ler/ Wife	20b. Place of cemetery	Disposity, crema	ammen Av	e. Timo	nium, Md Date	210 20c. Loc	Ac. County of Death Baltimore 9. Birthplace (State or County) 16, 1928 Maryla 10d. Inside City 1 yes Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White b. Kind of Business/Industry Engineering iden Sumame) ify or Town, State, Zip Code) 21093 C. Location - City or Town, State Fimonium, Md. 10d. Approximate Interval Betwo Onset and Death 23d. Date of delivery Month Day Ye 23d. Date of delivery Month Day Ye 23d. Date of delivery Month Day Ye 23d. Date of Gelivery Month Day Ye		
Baltin	permit. Pa Departmer Important eny injury once.	Ī	*4 □Donation 5 □Other (21. Signature of Fune/al Service	e Licy se		22.1	lley Mem Name and Addres Ruck	s of Facility	3-04 Funeral			Md.	
•	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	aused the death. Do not ach line. Froke or as a consequence of	•	the mode of dying	YDTK KD , such as cardia	• I OWSON	rrest,	21204	Interval Betw	veen
6 0325 8760, 7	rate be executed by systems and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Oue to (c	or as a consequence of	of):							
3(-04	the death certific y the attending p ched for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live bi	come of pregnancy rth 2 Petal death ant at time of death wn		ctopic pregnancy Other (specify)			23		,	ea r
ords, P	w requires that the been signed by th should be detache	ted by Ph	Part II. Other significant condit	<i>1</i>		the unde	erlying cause give	n in Part I.	23e. Did to	_	_		
A Reco	The law cate has b page 2 sl		•								prior to cor death?	npletion of ca	variable use of
Sion of Vit	hys his	ation; To Be	25. Was case referred to medic examiner? 1 Yes	Hospital: 1 ☐ In 28a. Date o	ppatient 2 ER/Outp f Injury 28b. Tir n, Day Year) Inj		3 DOA Other	1. 4 ☐ Nursing I		ience 6		Hosp	lice
Divisi	spital or Attendous after death ours after death serel Director: , filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At home, farm g, etc. (Specify)	m, street			28f. Location (S City or Tou	Street and i vn, State)	Number or Rura	Route Numb	Θ <i>r</i> ,
0	the Hospi nin 24 hou the Funer npletely fill	Medical	one)	and mann	sis of examination and/	death o	ocurred at the time stigation, in my opi	e, date and plac nion, death occ	e, and due to the ourred at the time,	cause(s) ar date and p	nd manner as sta lace, and due to	ated. the cause(s)	
	or with	2	29b. Signature and title of artific	Konykul	ey, mo		29c. License	number		Janu	signed (Month, I	Day, Year)	٣
2	O'		30. Name and address of person A. R. Ley 31. Date filed (Month, Day, Year	who completed cause	death (Item 23a) (T	ype, Pri	larles .	H. Bal	to. Md	21	704		
	Stat Registra	100		EB 0 3 200		J.	Spark.	g.					

			1 - For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of rtificate of		d Mental Hy	giene2	02847
	Physic	ian	Decedent's Name (First, Middle, James Andrew		i o 1 d			2. Date of De Month		3. Time of Death
	/Medi Exami	cal	4a. Facility Name (If not institution,	give street and number		4b. City, Town,	or Location of E	Januar Death	4c. Coun	2004 3:55A M hty of Death
	Funeral Director		00000	. Sex 7. /	Age (In yrs. last birthday) 49 Yrs.	If Under 1 Yea Months Days	r If Under 24	Hrs. 8. Date of Bir (Month, Date of Bir 100 100 100 100 100 100 100 100 100 10		Birthplace (State or Foreign Country)
			Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation		02 10		Michigan 10d. Inside City Limits
	death with the Maryland ms 23e or 28e-f show Imast be redified at	ctor	TN Knoxs		Knoxvi					1 Ves 2 □ No
	with the	Director	10e. Street and Number	- 4 4 -		10f. Zip Code			10g. Citizen of	f What Country?
	heath w	Funeral	806 Kemberlin H	12. Was Deceder		Was Decedent of		? (Specify Ves or No	USA 14 Ba	A ace - American Indian,
920	hours after o turel', or iter	þ	1 Never Married 25 Married 3 □ Widowed 4 □ Divorced	Armed Force	7-10-72	of Yes, specify Cu 1 ☐ Yes 2 ☑ No		? (Specify Yes or No uerto Rican, etc.)		ack, White, etc. ify: White
21215-0036	n 72 "ne "ne	Completed	15. Decedent's (Specify only highest	grade completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retir	upation e during most of ed)	working	16b. Kind of E	Business/Industry
212	be filed within ital Hygiene. Ind other than "event, the Mer	Com	Elementary/Secondary (0-12)	College (1-4o	1 5+)	linister			Se1f	Employed
Maryland	2 2 2 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Be	17. Father's Name (First, Middle, La Andrew J. Porte					Name (First, Middle,	Maiden Suma	
aryl	s 1 and 2 should be f Health and Mental item 27 is marked o	은	19a. Informant's Name/Relationship		19b. Maili	ng Address (Stree		e Lorene		1, State, Zip Code)
	and ealth n 27		Judy Porterfield	Wife	806 k	Cemberli		s Rd. Kno		TN. 37920
Baltimore,	Page ent o nt: If		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		20b. Place of Dispo cemetery, crea Atchley S Memory Ga	sition (Name of matory or other pla Seymour arden	ace) 1-	Date -26-04	20c. Location Seymour	- City or Town, State
Balt	permit. Departm Importer eny inju		21. Signature of Funeral Service Lic	censee	22	. Name and Addr	ess of Facility	Marshall' N.W. Wash		al Home D.C. 20011
8760,	physician and steep be executed physician and steep burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, that y, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	is a consequence of):	g dis	asc			Onset and Death Months 11 months
O. Box 6	The law requires that the death certificate be executed ate has been signed by the affending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnanc	cy		1	ate of delivery onth Day Year
rds, P.	w requires that been signed t should be deta	þ	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to		tribute to the cause of death? 3 Probably 4 Unknown
of Vital Records,		Completed						24a. Was a autop perfor	med?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vita	Physiclen: The this certificate hare al director, page	Be	25. Was case referred to medical examiner?	Hospital: .		- Ott		Death (Check only or		
on of	ng Pt fter th	tlon: To	1 ☐ Yes 2 ANo 27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of In (Month, D	jury 28b. Time of	28c. Inju	4 🗀 Nursin	g Home 5 Resid		
Division	Hospitel or Attending 14 hours after death. Funerel Director: Afte tely filled in by the fune	Certification;	3 Suicide 6 Could not determine	be 28e. Place of I	njury - At home, farm, stre tc. (Specify)			28f. Location (S City or Tow	treet and Numb n, State)	ber or Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying I (Check only one)	Physicien: To the best aminer: On the basis	t of my knowledge, death of examination and/or inv tated.	occurred at the ti estigation, in my	me, date and pla opinion, death o	ace, and due to the courred at the time, d	ause(s) and ma late and place,	anner as stated. and due to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier			29c. Licens	se number	2		d (Month, Day, Year)
			()	1			53281		01/22	2/04
	V		30 Name and address of person who	Completed cause of KAN6	death (Item 23a) (Type, I		VE RE	THEGDA	MD	20892
	Sta		31. Date filed (Month, Day, Year)				, , ,	1110701	1.0	2012
	Registr	ar	FEB 03	2004	trar's Signature	and I				

		1 - For State Registrar 1. Decedent's Name (First, Middle, Las			ertificate			Re	g. No. 201	Or 104 Or 1
Physici	an	David John Popilok						Month	Day Ye	
/Media		4a. Fecility Name (If not institution, give			4b. City,	Town, or Loc	ation of Death	January	Ac. Country of Death Baltimore ate of Birth Adonth, Day, Year) 10g. Citizen of What Country? 10g. Citizen of What Country? United States (es or No- 16b. Kind of Business/Industry Baltimore City Maryland 16b. Kind of Business/Industry Baltimore City Milson te Number, City or Town, State, Zip Code) e, Maryland 21228 20c. Location - City or Town, State ABaltimore, Maryland 2 Approximatory arrest,	
LAGIIII		405 Oak Court				tonsvi				
Funeral		5. Social Security Number 6. Se		(In yrs. last birthda		1 Year If I	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day,	Day Year 28, 2004 9:40 4c. County of Death Baltimore Year) 9. Birthplace (State Country) 1939 Maryland 10d. Inside Country? United States 14. Race - American Indian, Black, White, etc. Specify: White Sb. Kind of Business/Industry Baltimore City Aiden Sumame) On City or Town, State, Zip Code) Cyland 21228 Dc. Location - City or Town, State altimore, Maryland Peral Home, Inc. Dre, Maryland 21.2 Approximation of Country and Death? Approximation of Country and Death? 23d. Date of delivery Month Day 24b. Were autopsy findings prior to completion of completion of country and Death? 23d. Date of delivery Month Day 24b. Were autopsy findings prior to completion of completion of country and Death? 24b. Were autopsy findings prior to completion of country and Death? 27d. Date of delivery Month Day 24b. Were autopsy findings prior to completion of country and Death? 25d. Date of delivery Month Day 25d. Date of delivery Month Day 26d. Date of delivery Month Day 27d. Date of delivery Month Day 27d. Date signed (Month. Day, Year) 28d. Date signed (Month. Day, Year)	Birthplace (State or Fore Country)
Director		Usual Residence of Decedent	Ž M 2□F	65 Yrs.				Jan 13,		
-f show	tor	Maryland n/a		10c. City, Town or Baltimo						10d. Inside City Lim
a or 28a	Funeral Director	10e. Street and Number 1212 W. Cross Stre	et.		10f. Zip	Code 1 230		10	-	
ms 23	era	11. Marital Status	12. Was Decedent B	ver in U.S. 13			nic Origin? (Sp	ecify Yes or No-		
Department or reatin and wenter Hygiene. Department: If the Z7 is marked other than "natural," or items 23e or 28e-1 show any injury or other traumatic event, the Modical Examine I had be nutitied at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	If Yes, spec 1 ☐ Yes 2		lexican, Puerto pec <i>ity:</i>	Rican, etc.)		
"nature	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	(Ĝi	edent's Usua ve kind of wor DO NOT us	k done durin	g most of work	ing	6b. Kind of Busine	ess/Industry
the s	mo	Elementary/Secondary (0-12) 12	College (1-4or 5-	+)	æ Offi	,			D-3+4	G! t
other ont,	BeC	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	POLIC	E OIL		Mother's Nam			CITY
Mental Brked atic ev	To B	John Joseph Popilo	k				Cather	ine Wilso	on	
le me		19a. Informant's Name/Relationship (T)								
realin tem 27 other tra		Deborah Lynn Welsh	- daughte							
or off		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	1	ematory or ot	ther place)	I			
Important: If Ite any injury or of once.		'4 Donation 5 □ Other (Specify,		Loudon F	ark Ce	emetery	y 2/2/	2004 Ba	altimore,	Maryland
Impo any ir		21. Signature of Funeral Service Acens	Zink	/						•
		23a Part 1 Enter the disease for comp	lications that caused							
	Ď.	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line	9.	THO THOU	5 01 dy 11g, 3d	on as caraiac i	or respiratory arres	11,	Interval Between Onset and Death
ysician ledical		disease or condition resulting in death)		eal Cance consequence of):	r					5 months
aminer			Due to (b) as a	consequence on:						
*	Jer	Sequentially list conditions, cause. Enter Underlying	b. Due to for as a	consequence of):						
nd ransi	Examiner	that initiated events	с.							
ian a urial-	Ex	resulting in death) Last	Due to (or as a	consequence of):						
physic the b	dical		d	-						
ed by the attending physician and detached for use as the burial-transit	by Physician/Med	IF FEMALE:	23c. If yes, outcome of	f prognancy						
atten for us	clan	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	☐Ectopic pre					
y the	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ane or death 3	□ Other (spe	эспу)				
deta	y Ph	Part II. Other significant conditions co.	ntributing to death bu	t not resulting in the	underlying ca	use given in	Part I.	23e. Did toba	cco use contribute	to the cause of death?
n signé ed blu		Alcoholic Cirrhos	is					1 ∑ Yes	2 □ No 3 □	Probably 4 Unknow
s been si Should I	Completed							24a. Was an	24b. Were	autopsy findings availab
nis certificate has l I director, page 2 s	E							performe	d? death	?
rtifica stor. p	a	25. Was case referred to medical				26.	Place of Death	(Check only one)	·	
this ce al direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie	ent 3 DO	04		me 5□Residen	ce 6 1 €Other (Si	Daughter's
After thi		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time	of 28	c. Injury at Work?			injury occurred 1	residence
or: A	catl	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗌 Yes	2 🗆 No			
	Certification;	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	treet, factory,	office	:	28f. Location (Stree City or Town, 3	et and Number or State)	Rural Route Number,
Director:)	()	29a. Certifier 1/X Certifying Phy	sicien: To the best of e	examination and/or i	th occurred a	it the time, da	ate and place, a	and due to the caused at the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)
Funeral Direct		(Check only 2 Medical Exemi	and manage stat	ea.						
o the Funeral Direct	Medical C	(Check only one) 2 Medical Exemi	and manner state		29c	License num	ber	294	Date signed /Mo	oth Day Yearl
To the Funeral Director: completely filled in by the	edical	one) 2 Medical Exemi	and manner state			License num	nber		_	
To the Funeral Direct	edical	one) 2 Medical Exemi		ath (Itam 23a) (Tuna	D4	License num	nber		_	

			1 - For Stete Registrar	State	of Marylar		artment of H			giene 2	004	0284
	Physici		1. Decedent's Name (First, Middle Diana Doris						2. Date of De Month Janaur	ath Day	Yeer	3. Time of Death 9:30 a M
	/Medio Examin		4a. Facility Name (If not institution		ımber)		4b. City, Town, or	Location of Deat			ty of Death	4
+			1225 Greystone		1 "		Arbutus				imore	
	Funeral Director		5. Social Security Number 214-26-4211	6. Sex 1 □ M 💥 F	7. Age (In yrs.	75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year)	9. Birthp Cour Mary	place (State or Foreign ntry) 1 and
	pu * II		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ity, Town or Lo	cation		, Joop . 23	, 1,20		0d. Inside City Limits
	Maryla	to	Maryland Baltim	ore		outus	oution					1 ☐ Yes XX No
	or 288	Director	10e. Street and Number	010	2111	Jacas	10f. Zip Code			10g. Citizen of		,
	s 23a	rai	1225 Greystone				21229			United of Amer	ica_	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show says injury or other treumatic event. In Medical Exactions treat the rotified at ODGs.	by Funeral	11. Marital Status 1 □ Never Married 【【】Marri 3 □ Widowed 4 □ Divorced	Armed F	X XNo ive		Was Decedent of Hi f Yes, specify Cuba I□Yes XX No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14. Ra Bla Speci	ice - Americ ack, White, ify: Whit	etc.
ב כ	72 hc	eted	15. Decedent (Specify only highes	's Education t grade completed,		(Give	lent's Usual Occupa	furing most of wor	tking	16b. Kind of E		
7 .	within iene. then	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		00 NOT use retired, ervisor)		Westi	nghou	Se
2	at Hyg I other	BeC	17. Father's Name (First, Middle, I	ast)		Jup	1	18. Mother's Nar	ne (First, Middle,			
Ž	ould b	70	John Ernest Mad					Hilda 1				
2	and 2 sh ealth and n 27 is n	İ	19a. Informant's Name/Relationsh Kathleen M. Lem		thtor)		g Address <i>(Str</i> eet a ointe Ver					
Ď,	of Hea		20a. Method of Disposition		20b. I	Place of Dispos	sition (Name of natory or other place	-)	Date	20c. Location		
	Pages 1 Iment of H tant: If Ite jury or oth		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	Olulo	idon Pa	rk Cemete	ry 2004		Baltimo	re, M	aryland
2	permit. Departn Imports sny injk		21. Jignatur of Funera Same L	arty.			. Name and Addres	362 Bal	ıdon Parl 20 Wilkeı timore,	k Funer ns Aven Marvla	al Ho	me
	- AF		3a. art1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that only one cause on	caused the deat	th. Do not ente		g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Me	(or as a conseq	CC SI	nall a	ell her	ng la			lyear
	Examiner		Sequentially list conditions,	1 , 8	main	met	astase	5				O .
	be tis	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):						-
	execut n and ial-trar	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	juence of):						
Š	icate be executed physicien and s the burial-transit	dlcal		d						,		
Š	certifica ding ph se as t	/Med	IF FEMALE:	220 If you av	tooms of proges							
	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live I	tcome of pregna pirth 2 □ Feta nant at time of d own	Il death 3 🗌	Ectopic pregnancy Other (specify)				ite of delive onth	ry Day Year
5	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to d	eath but not res	ulting in the un	derlying cause give	n in Part I.	23e. Did to			e cause of death?
		Completed							24a. Was a autop: perfor	sy med?	Were autop prior to con death? 1 Yes	esy findings available apletion of cause of
	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			Otho	26. Place of Dea	,			
5	g Phys er this eral di	\vdash	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	Inpatient 2 of Injury th, Day Year)	ER/Outpatient 28b. Time of	3 DOA 28c. Injury Work	4 U Nursing H	ome 5L Hesid)
	Attending I or death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investiga	ation	in, Day rear)	Injury		? es 2 □ No				
	or Attend after death Director: A In by the f	Certification;	3 Suicide 6 Could no 4 Homicide determin	288. Place	of Injury - At hoing, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (S City or Town	treet and Numb n, State)	per or Rural	Route Number,
•	spitel		29a. Certifier 1 Certifying	Physician: To the	best of my kno	wiedge, death	occurred at the time	e, date and place.	and due to the c	ause(s) and ma	anner as sta	ated .
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	edical	one)	xaminer: On the b	asis of examina	ition and/or invi	astigation, in my opi	nion, death occur	red at the time, d	ate and place	and due to	the cause(s)
	or time	Σ	29b. Signature and title of certifier	a 0.0	_		29c. License	number	2	9d. Date signe	d (Month, E	Pay, Year)
	0		30. Name and address of person w	the completed cause	se of death (Item	1 23a) (Type, F	29c. License (5) Print) 27 St. (6)	300 Otions	000	D 31-	0/04	
	Stat	te	31. Date filed (Month, Day, Year)	32. P	egistrar's Signa	iture	1671, 6	Juli III	ou III	V 41	-63	
	Registra		ren 0 3	2004	Bally But	Mr A	set 1					

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year OISI AM 2004 /Medical February 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 108M 2□F Director ainla Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be nytified at NIA BALTIMORE 1 PYes 2 □ No Directo 10f. Zip Code 10g. Citizen of What Country? USA 12 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Black "natural". other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementally/Secondary (0-12) College (1-4or 5+) truction other Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Sumame) To Be should be find Mental F John ationship, (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 21229 Cousin Cook al TO 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State injury or *4 □Donation 5 □ Other (Specify)

21. Signature Funeral Service Ligensee any luga 23a. Part I. Enjor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BLRED GASTRO Physician IN TES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed the attending physician and thed for use as the burial-fransit Due to (or as a consequence of) Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of dea 🗷 Records, 1 ☐ Yes 2 ☐ No 3 Probably Completed 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate Division of Vital 1 Yes 2. No director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1_Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide ö To the Hospital Procedured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title a certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CURTS MUSPITAY TNRS MMI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Parham, John

ORIGINAL

			11000	State of Ma	andan	d / Departm	ent of Health and	d Mai	ntal Hygic	ne	,		
			For State Registrar	State of Ma	aryları	•	ate of Death	u iviei		. No. 2	004	028	351
			1. Decedent's Name (First, Middle,	Last)				2.	Date of Death	Davi	Vaaa	3. Time of	Death
	Physicia		Lonzetta	Planter					Month	30	Y997	304	A -M
ja.	/Medic Examin		4a. Fecility Name (If not institution,	rive street and number)		4b. C	ity, Town, or Location of De	eath		4c. Coun	ty of Death		
	LAGIIIII	·	University of 1	Naryland	Hos	nital	Baltimor	e		Bat	timo	re Co	tu
-	Funeral		5. Social Security Number 6	Sex 7. Ag		ast birthday) If Un	der 1 Year If Under 24 h	Hrs. 8.	Date of Birth (Month, Day, Y	eer)	9. Birth	place (State o	r Foreign
	Director		213-36-2749	1□M 2XF	6.	3 Yrs. Mont	ns Days Hours IV		ULY 04.	194C		RVL	AND
	g g		Usual Residence of Decedent						/ /				
	how		10a. State 10b. County	1 7	10c. City	, Town or Location	0		1	1		10d. Inside Ci	ty Limits 2 ☐ No
	e Ma	cto	MARULANO	NA			SALTIM	OR	ECI	TY		122,183	20140
	death with the Maryland ms 23a or 28a-f ahow	Director	10e. Street and Number			10f.	Zip Code		10g	. Citizen o	f What Cou	ntry?	
	15 w	ie I	1037 W.	LOMBA	RD-	ST.	212	22:	3		15A		
	eme eme	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. Was De If Yes,	cedent of Hispanic Origin? specify Cuban, Mexican, Pu	? (Specification (Specification)	y Yes or No- an, etc.)		ace - Americack, White,		
9	afte or it	F	1 Never Married 2 Marrie	If Yes, Give	No		s 2 No Specify:			Spec	ity:		,
5-0036	hours after tural', or Ita	d by	3 Widowed 4 □ Divorced	Year or Dates:			•				YOL	ACK	
,	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Decedent's U	work done during most of	working	16	b. Kind of	Business/In	dustry	
2	ne han	m d	Elementary/Secondary (0-12)	College (1-4or 5	5+)	1)	Tuse retired)	0		Ó.	1,/2	40.00	100
7	filed within 72 Hygiene. other then "ne ent, the Medic	ပိ	10 tHGRADE 17. Father's Name (First, Middle, La	et)	·	1101	MEMAKE		First, Middle, Ma	iden Sum		tom	
SE .	be fi	Be	17. Fallier's Name (First, Middle, Ca	31/	1	0000		7 1 1 1 1 1 1	77 GT, 1770-070, 1770	< T	2	()	
<u> </u>	2 should and Men is marke aumatic	7	19a, Informant's Name/Relationshi	(Time Brief)	/1/	10h Mailing Add	ress (Street and Number of	obumic	Pouto Alumbar C	O/Z	- VEN	Code	
Maryland			0	TITE DO DANG	(ITER)	50 Mailing 2001	P A L A . DA	PA	120	TIM	and A	10 7	1229
	1 and Health am 27 sther tr		PATRICIA GAIT 20a. Method of Disposition	HER (DAUG	20b. P	face of Disposition (Name of	Date	20	c. Location	- City or Te	7/) · OX /	221
<u>o</u>	Pages nent of h int: If its iry or of		1 ⊠Burial 2 ☐ Cremation 3		C	emetery, crematory	or other place)	4 .	- 11/1	. /-		/	
timore,			'4 □Donation 5 □Other (Spe		MI	IZION	EMETERY DO	(-0.	5-09 6	ANS	Down	JE, MAK	ZYLAND
Ba	permit. Departn Imports any inju		21. Signature of Funeral Service Li	ensee	11.	22. Nami	and Address of Facility	Rou				Home	5 . 7
	4038Q		Lunian	10. Del	em.	10 21	90 N. FUL	TON			TO. 14	Approximat	2//
n			23a. Part1. Enter the disease, or c shock, or heart failure. List of	mplications that caused by one cause on each li		()		Olac or it	aspiratory arrest	1		Interval Bet Onset and	ween
	Physician		Immediate Cause (Final disease or condition	- a. TOXIC.	- me	Tabolic	enceph	alo	pally				
	/Medical Examiner	1	resulting in death)	Due to (or as	a conseq	uence of):	/						
	LXammer		Sequentially list conditions,	b									
	Si &	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	dence or):							
	and -tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	2 CORSAG	nence of):							
760,	ate be executed hysician and he burial-transit			500 10 (01 23	a conseq.	dones (3).							
687	cate I	dicai		d									
9 ×	ding p	/Me	IF FEMALE:	23c. If yes, outcome	of preana	no.				00.15			
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant a	2 Feta	I death 3 Ectop	c pregnancy			1	ate of deliv Month		Year
o.	the a	ysic	1 ☐ Yes 2X No 9 ☐ Unknown	9□ Unknown	t time or o	eath 5 ☐ Other	(specify)						
Division of Vital Records, P.O.	ires that the death certificat signed by the attending phy d be detached for use as th	by Physician/Med	Part II. Other significant condition	s contributing to death b	out not res	ulting in the underlyi	ng cause given in Part I.		23e. Did toba	cco use co	ntnbute to t	he cause of o	leath?
S	sign and b					,			1 ☐ Yes	2 🗆 No	3 Proi	pably 4	Inknown
Ö	w requir been si should	etec						_					
ec	e law has b	npl						_	24a. Was an autopsy performe		prior to co death?	psy findings mpletion of c	available ause of
=	The cate	Completed								No	1 Yes	· 25/1 100	
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical exampler?	Magnitali				Death (Check only one)				
Ž	Physi this c	ပု	'17 ¥es 2 □ No	Hospital:					5 Residence			(y)	
n	ng P (fter 1	on:	27. Manner of Death 1 □Natural 5.□ Fending	28a. Date of Inju (Month, Da	ıry 1y Yeer)	28b. Time of Injury	28c. Injury at Work?	280	d. Describe how	injury occi	urred		
sio	eath. or: A	Certification:	2 Accident investiga 3 Suicide 6 Could no	t be		М	1 ☐ Yes 2 ☐ No						
Ξ	r Ati ter d irect	E	4 Homicide determin	ed 28e. Place of In building, et		ome, farm, street, fac y)	ctory, office	281	Location (Stree City or Town,	et and Nur State)	nber or Run	al Route Nun	iber,
	To the Hospital or Attanding Physicien: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the									4.1			
	Hosp 4 ho Fune fely fi	Medical	(Check only 2 Medical E	kaminer: On the basis of	of examina		red at the time, date and pi tion, in my opinion, death o						;)
	the tha tha	Med	one) 29b. Signature and title of certifier	and manner st	ated.		29c. License number		290	Date sign	ned (Month,	Dev Year)	
	To To		Selm K	Dario L'	-	m.D.			250	_			
,	0			TVWV			P 14653			01-	30 -	J4	
	8		30. Name and address of person w		death (Iten	n 23a) (Type, Print)	C.L. T) . ii		٨٨	7 -71	2 1	
				artin, M	rar's Sign	11 J. GT	eene St; I	salt	inore,	IYI	21	201	
	Sta Registr		31. Date filed (Month, Day, Year)	104 Megisti	iais Signa	ALL DE SEL	•						

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Neme (First, Middle, Last) Month Yeer **Physician** 1705 M Januar 2004 Cecile Maria Louise Post 28 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Union Memorial Hospital **Baltimore** N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 103-36-4690 Director MAR 23, 1946 Maine Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hygiens. Importent: If tem 27 is anarked other than "natural; or itema 23a or 28a-f ahow eny injury or other traumatic event, ite Modical Examinar must be notified at TOYES 2 No Directo Maryland N/ABaltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11 W. 20th Street Apt. 17A 21218 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leon Bourgoin Azilda Morneault 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 129 Millet Creek Road Melbourne Feach, Fr. 32951 Be of Disposition (Name of Date 20c. Location - City of Town, State Beulah J. Moss/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 1/30/04 Baltimore, MD 21. Signature of Funeral Service Licery Cremation soften of Maryland, Inc. Dawn F. 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stege Renal **Physician** years /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifies AT 2438946 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University Perkuzy, Baltimore, SHARMA 201 E. SANDEEP 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dorothy E. Peddicord 04 - 0740State of Maryland / Department of Health and Mental Hygiene AKG Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 26, reddi cord January 2004 18:50 Dorothy E-/Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 603 South Ann Street Baltimore Apt. 610 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 10 M 2 F -36-8120 66 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or itams 23a or 28a-f ehow Exarciner roust be notified at 1 Pres 2 No Completed by Funeral Director NIO MOTP 10g. Cilizen of Whal Country? 10f. Zip Code 10e. Street and Number ANN 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 2 1NO Never Married 2 Married 1 🗌 Yes Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene.

Is marked other then "natureumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housing maid 3Rd 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Peddi Cord ITENE JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le any injury or other treu <u>00058</u>. Baltoma 21223 Emily No 20a. Method of Disposition dad 107 S carrollton NVE +i Vi Na 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) lawn 22. Name and Address of Facility was sey chars 21. Signature of Funeral Service Licensee フィ・ナル Wesley Balto md. 23a. Part1. Enter the disease of complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure of its only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence Mother (Specify) At SCENE 1XXes 2 No 2 ER/OutpatienI 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner slated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. January 27, 2003 Name and address of person who completed cause of death (Item 23a) (Type, Print) ASONICA 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

0 3 2004

Physicism Accident Francisco Fr	For		• •	-	artment of H	Health and N	Mental Hygier	-	00001
The company of the co	Reg	istrar		Ce	ertificate of	Death		No. 2 U U 4	02824
Cockeysville Cock							Month (Day Yeer	
FOUNDATION FOR TOTAL	/Medical				4h Cihr Toum o	y Location of Death			2:30 P™
Source S	Examine		street and number)					•	
Difference of December Section	T. O	Security Number 6. Se		(In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
The second of th		34-5446	□M 201 F	94 Yrs.	Months Days	Hours Min.	October 2	1909 Mar	ryland
Continue Continue	9			10a Cit. Taurant					
Continue Continue	Mary.	land Baltimo	re						
Continue Continue	10e. Stre 1380)	1 1 1 1		
Continue Continue	036 us atter dea 11. Marit 12. Marit 12. Marit 12. Marit 13. Mari	Never Married 2 Married	1 ∐Yes 2 X No If Yes, Give	ver in U.S. 13.			pecify Yes or No- Rican, etc.)	Black, White,	etc.
Continue Continue	215-0(215-0(1) 72 houseless that the property of the property	(Specify only highest grad	de completed)			pation during most of work d)			dustry
Continue Continue	Con Con		44	no	memaker				
Common Source Common Sourc	Duran de la la la la la la la la la la la la la	•	er			Tempera	ance Heste	r	
Common Source Common Sourc	Mary She and 2 she and 2 she and 2 she and 2 stream she and 2 stream she and 2 she and 3 stream she and 3 st								Code)
Common Source Common Sourc	20a. Met		Damoual from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place	ce)	Date 20c.	Location - City or To	wn, State
Physician Medical Examiner 23	Page 140			Greenmou	nt Cremat	ory Jan.	30,2004 Ba	ltimore,	Maryland
Physician (Medical Examiner) Physic		ature of Funeral Service Licens Dohn O. Mutc.	hell	2	2. Name and Addre Mitche 6500 Y	s of Facility 11-Wieder	feld Funera	al Home I	nc.
Due to (or as a consequence of): Sequentially (its conditions) Sequentially (its conditions	Claveleles Immedia	te Cause (Final	lications that caused to one cause on each line	he death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arrest,		Approximate
Due to (or as a consequence of): The tenth of the control of th	/Medical resulting	in death)	a. Due to (or as a	consequence of):	110				35000
Due to (or as a consequence of): The tenth of the control of th	Sequent lary, to cause. E. Cause (I.	ially list conditions, aum g to immodiate Enter Underlying Disease or injury	b. One to (or se a	consequence of);					
The content of the	760, be exect sician and surial-transferance burial-transferance.	in death) Last	Due to (or as a	consequence of):					
The state of the			d						
25. Was case referred to medical examiner? 1	O. Box he death cert he death cert ribe attending ched for use up to the standard or use up to the standard or use 10 10 10 10 10 10 10 10 10 10 10 10 10 1	s decedent pregnant ne past 12 months? Yes 2 🗹 No	1 Live birth 2 4 Pregnant at ti	Fetal death 3		,			•
25. Was case referred to medical examiner? 1	ds, P. Uries that uries that a signed by Ph d be detail of by Ph	ther significant conditions co	intributing to death but	not resulting in the L	inderlying cause giv	en in Part I.			
25. Was case referred to medical examiner? 1	w red shows show and shows a show a s	CHE					24a Was an	24h Were auton	nsv findings available
The state of the s	al Real Relation of the last o						autopsy performed? 1 Tyes 2 12 N	prior to com death?	rpletion of cause of
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Ite 23a) (Type, Print)	exame exame	iner?	Hospital:	2 T T T T T T T T T T T T T T T T T T T	Oth	000		. 50	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Ite 23a) (Type, Print)	After this To To To To To To To To To To To To To	er of Death			f 28c. Injur	y at k?)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Ite 23a) (Type, Print)	or Attendation by the artificat	Suicide 6 Could not be	200. Flace of injur	y - At home, farm, st (Specify)			28f. Location (Street a City or Town, Sta	and Number or Rural ite)	Route Number,
30. Name and address of person who completed cause of death (Ite 23a) (Type, Print)	Hospital Hospital Thomas Sar Cer Cov.	eck only 2 ☐ Medical Exami	iner: On the basis of e	xamination and/or in	h occurred at the tin	ne, date and place, pinion, death occurr	and due to the cause(s) and manner as stand place, and due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Ite 23a) (Type, Print)	g c g b b c g b c		and manner state	eu.					
BARBARA CARROLL, M.D., 13801 York Rd., COCKEYSVILLE, MD	→ + ≥ + 2	Barbara	Carro	U. M.	D D	38392	\ /	127/21	04
31 Date filed (Month Day Year) \$ 30 Pagistraria Signatura &	30. Name	and address of person who co	ompleted cause of dea	ath (Ite 23a) (Type	Print)	4 81	cock		40
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature FFB 0 3 2004	State	filed (Month, Day, Year)	32. Registrar	s Signature		1)	9	1110

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rodinsky Month **Physician** Rosemarie January 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard County General Hos oward If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) State 1 □ M 2 💢 F Days Hours 535-24-1156 79 1925 Washington Director Jan. 13, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location *show 10d. Inside City Limits event, the Medical Examinar must be mutified at MD Howard Elkridge 1 ☐ Yes 2 No 28a-f Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 238 6519 Tufts Drive Funeral 21075 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes XXNo Completed by Specify: Specify:white 3 ₩ Widowed 4 Divorced Year or Dates natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 PSVC Tech Mental Health Hospi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Richardson Ruth Crawford Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Earlene K. Coker-Rand/dghtr 11789 Stonegate Lane, Columbia, Md. 21044 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or of 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Balto/Wash, Crem. 01/31/04 LAurel, Md. 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Se 07. 5555 Twin Knolls Rd. Columbia, Md. 21045 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bilalesell resulting in death) /Medical Due to (or as a consequence of) Examiner 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit certificate be executed and Due to (or as a consequence of): Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be canun 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation or Attendation of the death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 🗀 Homicide within 24 hours a To the Funeral D to Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie 29c. License number D50850 B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Un. Clarksulle MD suzan HOOO, MI 5005 opport 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 3 2004 Registrar

			1 - For State Registrar	State of Maryland / Depart	rtment of Health and Nificate of Death		°2004 02856
	Physici /Medi Examir	al	1. Decedent's Name (First, Middle, Last ALTER 4a. Facility Name (If not institution, give HILLER 5. Social Security Number 6. Se 0.146 - 244 640 7 115	N RINGGOL street and number) ANC, Apt 2A	D SR 4b. City, Town, or Location of Death BOHIMOR If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	2. Date of Death Month D	Pay Year 3. Time of Death 9 2004 2:05 p Mm lc. County of Death
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any njury or other treumatic event, the Macalical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationshi 19a. Informant's Name/Relationshi 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licens	10c. City, Town or Loc A P A 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: Cotlege (1-4or 5+) College (1-4or 5+)	as Decedent of Hispanic Origin? (Spress, specify Cuban, Mexican, Puerto Yes, Specify: Int's Usual Occupation and of work done during most of work on the during most of work on the during most of work on the during most of work on the during most of work on the during most of work on the during most of work on the during most of work on the during most of work of the during most of the during most of work of the during most of the durin	acify Yes or No-Rican, etc.) Ing 16b. (First, Middle, Maide) Route Number, City All 16b. 20c. 1	
760,	eath certificate be executed attending physicien and for use as the burlat-transit	Ical Examiner	23a. Part 1. Enter the disease, or complishock, or heart dailure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. Do not enter the cause on each line. CHF Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	the mode of dying, such as cardiac of	r respiratory arrest,	Approximate Interval Between Onset and Death
Vital Records, P.O. Box 68	The law requires that the date has been signed by the page 2 should be detached	Be Completed by Physician/Med	was decemble peginally in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions con CR + Hyp(Anemio		ctopic pregnancy Other (specify) erlying cause given in Part I. 26. Place of Death	1 Tyes 2 24a. Was an autopsy performed? 1 Yes 2	23d. Date of delivery Month Day Year use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of V	or Attending Phatter death. Director: After thin by the funeral	Certification; To	27. Manner of Death 1-	ospital: 1	3 DOA Other: 4 Nursing Hor 28c. Injury at Work? M 1 Yes 2 No t, factory, office	ne esidence 28d. Describe how inju 28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
	To the Hospitel within 24 hours. To the Walkin 24 hours. To the Eunerel Completely filled		29b. Signature and title of certifier	mpleted cause of death (Item 23a) (Type, Pr	29c. License number 70 5 7 2 8	ed at the time, date an	ate signed (Month, Day, Year) N 30 2004 NORE, MD

		•	1 - For State Registrar	State of Maryland /	Department of Health and Certificate of Death	Mental Hygien	EOUN ULL	357
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	M	ROGERS	2. Date of Death Month 24	3. Time of	Death Qui
	Examin		4a. Facility Name (If not institution, give	street and number) 2 HOSOital	4b. City, Town, or Location of Dea	^	c. County of Death	
	Funeral Director		5. Sobial Security Number 6. Sec. 11	7. Age (In yrs. last b	oirthday) It Under Year If Under 24 Hrs Yrs. Months Days Hours Min		8. Birthplace (State of Country)	or Foreign
	nyland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location		10d. Inside C	•
	h the Ma or 28e-1 s e notifies	Funeral Director	10e. Street and Number		Battimore 101. Zip Code	10g. C	itizen of What Country?	2 No
	death wit	neral D	2596 W. Fay	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (s It Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28e-f show or other traumatic event, the Madical Examinar must be notified at		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	no Rican, etc.)	Specify: BIACK	
21215-0036	within 72 ho ene. than "natur ne modell	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (Q-12).	ucation 16 completed) College (1-4or 5+)	ia. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking 16b. I	Kind of Business/Industry	
	filed with Hygiene other the		17 Father's Name (First, Middle, Last)	NA	HOMEMOKER 18 Mother's Na	me (First, Middle, Maide	Sumame)	
Maryland	2 should be and Mental is marked o	To Be	Specific Control 19a. Informant's Name/Relationship (7	CC yos. Print)	Pb. Mailing Address (Street and Number of R	Pural Route Number, City	or Town, State, Zip Code)	
	1 and 2 s Health ar sm 27 is ther trau		Shella R. Rox 20a. Method of Disposition	gers (bottr) 2	2596 W. Fayette	y Batte	ocation - City or Town, State	වර
altimore,	Pa men ury		1 Burial 2 Cremation 3 C	Removal from State Gari	rison Forest 02	02-04 Ou	ungs Mills.	MD
Bal	permit. Departr Imports any inj		21. Signature of Funeral Service Licen	Jan	5151 Balto. Nat	inghn (Gre 1 Pike Ba	Himore, MD2	via 1229
E	Physician		23a. Part1. Enter the dishase, or comp shock, or heart failule. List only of Immediate Cause (Final disease or condition	lications that caused the death. Done cause on each line.	o not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximat Interval Bet Onset and	ween
*	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):		Ode	Y
	rted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	o of):			
,09	ficate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	e of):			
x 68760,		/Medical	IF FEMALE:	d 23c. If yes, outcome of pregnancy				
P.O. Box	that the death certifined by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day	Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of PYE VIOUS	ontributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the cause of c	death? Jnknown
of Vital Records,	9 4 9	Completed		,		24a. Was an autopsy performed?	24b. Were autopsy findings prior to completion of c death?	available ause of
/ital		Be Co	25. Was case referred to medical examiner?			1 ☐ Yes 2 Neath (Check only one)		
n of \	Phys this al di	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending		Outpatient 3 DOA Other: 4 Nursing Time of Injury 28c. Injury at Work?	Home 5 Residence 28d. Describe how inju		
Division	al or Attending atter death. I Director: After d in by the tune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M 1 ☐ Yes 2 ☐ No farm, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Num	iber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely tilled in by the tuner	al Cer	29a. Certifier Certifying Ph	ysicien: To the best of my knowled	ge, death occurred at the time, date and plac	e, and due to the cause(s	and manner as stated.	
K.	To the Hospital within 24 hours a To the Funeral completely tilled	Medical	(Check only one) 2 Medicel Exemone) 29b. Signature and title of certifier	and manner stated.	and/or investigation, in my opinion, death occ 29c. License number	29d. D a	ate signed [Month, Day, Year)	
	⊢ s ⊢ ŏ		I fufat >	Girges	D31726			
_	V			completed cause of death (Item 23a	D31724 1) (Type, Print) 724 Maiden C	hoice La	· Cafonsvill	e MD
	Sta Registr		31. Date filed (Month Day, Year)	32 Registrar's Signature	Anaste)			

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 02858 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Kogers 09:55 AM Januar 2004 ecilia /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmore der 1 Year | If Under 24 Hrs. Boyview Medical Centr N/A Johns Hopkins 8. Date of Birth (Month, Dey, Yeer)
DEC. 19,1918 MARYLAND If Under 1 Year Months Days 9. Birthplece (Stete or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Hours 1 □ M 2√2 F 85 218-07-4309 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c, City, Town or Location Hygiene. other than "naturel", or flema 23e or 28e-f show ent, the Modical Examinat russt be notified at 10a. State 10b. County 1 X Yes 2 ☐ No Funeral Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 3121 McELDERRY STREET 21205 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC s 1 and 2 should be filed v if Heelth and Mental Hygie tem 27 is marked other to other traumatic event. In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM Ε. LIBKEY CLARA BROWNING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARSHA ROGERS/ DAUGHTER 3121 McELDERRY STREET, BALTIMORE, MD. 21205 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Itel
eny injury or ott
once. 1 □ Burial 2 XCremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 2/2/04 BALTIMORE, MARYLAND 22 Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD. 21. Signature of Funeral Service Licensee ales of the 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic shock **Physician** 24 hours /Medical Due to (or as a consequence of): **Examiner** pneumonia Justilobar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ la 1 Yes 2 No 3 Probably 4 Unknown hor Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 5 autopsy certificate 1 Yes 2 No pertension 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this funeral (27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Medical Doctor Res-600 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 600 North Wolfe St. John Nauyen, M.D. Johns Hopkins Hospital 31. Date filed (Month, Day, Year) 32. Registral's Signature State FFB 0 3 2004 Registrar

			1 - For State Registrar	State of Ma	ryland		artment rtificate			nd Me		iene 20	04	02859
E	Physici		1. Decedent's Name (First, Middle, Las	"Roo	K						2. Dete of Dea Month		Year.	3. Time of Death
1	/Medic Examir		4a. Fecility Name (If not institution, give	street and number)			4b. City, T	Town, or	Location of I		anuar	4c. County	of Deeth	13.00
			Johns Hopkins Br	nyview			Ba	Iti	nor	e				
	Funeral Director		5. Social Security Number 6. Se 216–14–4580	TH STE	(In yrs. Ia 80	st birthday) Yrs.	Months 1	1 Year Days	If Under 24 Hours	Min.	8. Date of Birth (Month, Dey		9. Birthp	lece (State or Foreign
in the			Usuel Residence of Decedent		00	173.					Dec. 11	,1923 N	Maryl	and
	arylan		10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
	Ba-f	ecto	Maryland Baltimor	9	Mic	ddle R	liver							1 ☐ Yes 🏂 No
	with the or o	Funeral Director	10e. Street and Number	Tonio			10f. Zip (0g. Citizen of W	Vhat Coun	itry?
	ms 23	era	1131 Susquehanna A	12. Was Decedent Ev	er in U.S.	13 V		220	nanic Origin	2 (Spac		U.S.A.	- Americ	on Indian
ဖွ	after or iten	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		1	_			uerto R	ify Yes or No- ican, etc.)		k, White,	
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23e or 28e-f show int, the Medical Examinal must be notified at	d by	XXWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			☐ Yes 2	XXXO	Specify:			Specify.	Whi	te
7	in 72	Completed	15. Decedent's Edu (Specify only highest grad	ication (e completed)		16a. Deced	ent's Usual kind of work OO NOT use	done di	tion uring most of	f working	,	16b. Kind of Bu	siness/Inc	dustry
212	filed with Hygiene. Ither than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		Cler		retirea)				T. G. G.		
9	be filed stal Hyg d othe avant,	BeC	17. Father's Name (First, Middle, Last)			CTGT	ν		18. Mother's	Name (U.S. GC		ment
yla	should be filed within 72 hours after death with the Marylan and Mental Hygiene. Indexed other than "natural", or liems 23s or 28s-f show unatic avant, the Medical Examiner must be notified at	To	Charles Adams						Anna 7	[adi	yeski			
Maryland	2 m m m		19a. Informant's Name/Relationship (T)	pe, Print)								City or Town, S		
	s 1 and if Health item 27 other tr		Gary Rook (Son) 20a. Method of Disposition		20h Pla	1638 ce of Dispos	Frenci	hs A	venue,	, Ba.		, Maryl		
<u> </u>			1 🔀 Bunal 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cen	netery, crem	atory or oth	er place,				0c. Location - (
baltimore,	permit. Page Department (important: If any injury or once.		21 Signature of Juneral Service Licens	96	11011	22.	Name and	Address	of Facility	2/2,	/ 2004 B	altimor	e, M	aryland
n	89 1 2 8		136				1407 (old :	uzdzir Easter	iski m Av	Funera Venue.	l Home,	P.A.	land 21221
	· · · · · · ·	200 A 4	23a. Part . Enter the disease, or compl shock, or heart failure. List only or	cations that caused the	e death.	Do not ente	r the mode	of dying,	such as car	diac or r	espiratory arre	st,		Approximate Interval Between
e F	Physician		Immediate Cause (Final disease or condition resulting in death)	cardia	CC	irrh	uth	mi	a					Onset and Death
ę	/Medical Examiner		Todaling in dealin)	Due to (or as a c	onseque				0					
	4	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequer	nce of	irat	01	110	11	ure			
	cuted nd ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Chroni	ic.	ohst	Tale.	tiv	Pa	Am	MANAM	1 dise	202	
Ď.			resulting in death) Last	Due to (or as a c	onsequer	nce of):		~ 1	1	QL.	UNICAL	10.30	300	
ò	cate b physic the b	dlcal												
X	ins aw requires that the death certiliste has been signed by the attending toage 2 should be detached for use as	/Me	IF FEMALE:	3c. If yes, outcome of p	pregnance	v			-4					
Ď	death d for u	iclar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 Live birth 2 ☐ 4 Pregnant at tim	Fetel de	eath 3⊟6	Ectopic preg Other (spec					23d. Date Mont		y Day Year
)	by the	Physiclan/M	9 Unknown	9□ Unknown										
ń	es ign	þ	Part II. Other significent conditions con	tributing to death but n	ot resultir	ng in the und	derlying caus	se given	in Part I.		23e. Did toba	icco use contrib	oute to the	cause of death?
ָה פרים פרים	need s	eted								-	1 🗌 Yes	2 □ No 3	Proba	bly 4 Unknown
ט פ	s certificate has b lirector, page 2 s	Completed								_	24a. Was an autopsy	pri	or to com	sy findings available pletion of cause of
נטו ל	ificate or, par	ပိ	25. Was case referred to medical		<u>.</u>						perform 1 ☐ Yes 2	No 1	ath? Yes 2	□No
	ysicile is cert direct	0 0	examiner?	ospital: 1 inpatient	2 □ EB	/Outpatient	3□ DOA	Other:			heck only one,			
5 á	After this funeral di	T:U	27. Manper of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28	Bb. Time of Injury		. Injury at Work?				ce 6 Other		
0 10	eath. Ior: Ai	catlc	2 Accident investigation	(Monin, Day 70		пциту	М		s 2 □No					
1	after d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (5	At home Specify)	, farm, stree	t, lactory, o	ffice		28f.	Location (Stre City or Town,	et and Number State)	or Rural I	Route Number,
a latin	ours sours sours substant	<u> </u>	29a. Certifier 1 Certifying Phys	Ician: To the best of m	ur ka awla	dee deeth								
7	within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exemin	ician: To the best of m er: On the basis of exa and manner stated.	ammauon	and/or inve	stigation, in	my opin	oate and pla ion, death of	ace, and ccurred a	due to the cau at the time, date	se(s) and mann and place, and	ner as stet d due to th	ed. 16 cause(s)
Į.	within Comp		29b. Signature and title of certifier				29c. L	icense n	umber		290	I. Date signed (Month, De	y, Year)
	1		· tama	Tatel	mi	0	2	23(110		Tr	nuceri 1	30	2004
	D		30. Name and address of person who cor	npleted cause of death	(Item 23	a) (Type, Pr	int)			~	2 1/3	mary)	
T.	State	e_	3. Date filed (Month, Day, Year)	32. Registrar's	Signature	KINS	TXI	YVI	ew) 1	Salta	more	0	
	Registra		EER 0 3 200	- 4	. B	5	a see			′				;

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	laryland	•			ealth an Death	d Me	ntal Hy	giene Reg. No.	200	+ 02	860
	Physicia /Medic Examin Funeral Director	20	1. Decedent's Name (First, Middle, La	st)						2.	Date of De Month	eath Day	Year	3. Time o	of Death
		mar.	THOMAS SPENCE								Jan.	23	2004		OA M
		er	4a. Facility Name (If not institution, give		r)				Location of D	Death			County of Oes	th	
			5. Social Security Number 6. S		nge (In vrs. I	ast birthday)		umbi r 1 Year		Hrs. 8	Date of Bi	rth	ward	thplace (State	or Foreign
				₽M 2□F	81	Yrs.	Months			Min. J	(Month, D	28 -	1922	Scot1	
			Usual Residence of Decedent						<u> </u>				· · · · · · · · · · · · · · · · · · ·		
			10a. State 10b. County		10c. City	r, Town or Lo	cation							10d. Inside C	•
	Ba-f a	cto	Maryland Howa	ard	Co	olumb.									2 1 No
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow appringing or other traumatic avant, the Medical Exaturity or other traumatic avant, the Medical Exaturity or other traumatic and once.	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?												
		rai	6193 Commadore	T	. F	6 40.1		1045		2 (04		U.S	A	niona Indian	
		'n	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWII						uerto Ric	an, etc.)		14. Race - American Indian, Black, White, etc.			
936		by										Specify: White			
21215-0036		ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry												
2	thin	To Be Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. I	DO NOT	ise retired)	working					
2	ygier ygier her th			4 Years		Prod	duce	r -	Audic	Vi	sual			one Co	•
and	be fill		17. Father's Name (First, Middle, Last,										,		
ž	hould d Mer narke		Andrew Mackenz		ce	10h Mailie	an Addres	s (Street a	Hele	n Bi	uchai	nan	Brown Town, State,	Zin Codo)	
Maryland	d 2 sl th an th an traur													Zip (300e)	_
	Heal Heal tem 2		Mrs. Sarah Spe	nce	20b. Pt	lace of Dispo	sition (Na	me of	ore C	t Date	COL	20c. Lo	ation - City or	Town, State	5
Baltimore,	eges ant of nt: If i		XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			emetery, cren				/27	/04	0-1			
Ħ	ortar injur		21. Signature of Fineral Service Licer	1588		22	Name a	nd Addres	s of Facility				ımbia,		
ä	Deperminant of the popular in properties of t		Adentiforal			V	Vitz	ke F	unera	1 Ho	omes	Inc	o	MD	2104
	Physician /Medical Examiner	ical Examiner	Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia Approximate Interval Between 1 Shock, or Heart faiture. List only one cause on each line. 1 Inc. 5555 Twin Knolls Road Columbia Interval Between 1 Inc.										(MARII		
	ificate be executed g physician and as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C											
8760,	sician buria														
89	tificate ng phy as the			u.											
Records, P.O. Box	v requires that the death cer been signed by the attendir should be detached for use	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Was decedent pregnant in the past 12 months? 1 Yes 2 No								23d. Date of delivery Month Day Year			
			Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
000											24a. Was		24b. Were autopsy findings available		
	The lav										auto perf 1 Yes	ormed?	prior to completion of cause of death? I □ Yes 2 □ No		
Division of Vital		BeC	25. Was case referred to medical	26. Place of Death (Check only one)											
	Phys this aldii	edical Certification; To B	examiner? 1 🗌 Yes 2 📉 No	Hospitat 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify)							city)				
			7. Manner of Death 1 Naturat 5 Pending	(Month, Day Year) Injury Work? M 1 □ Yes 2 □ No					28d. Describe how injury occurred						
sio	death. death. ctor: A / the fu		2 Accident investigatio 3 Suicide 6 Could not b												
DIX	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined	building, etc. (Specify)						City or To	ation (Street and Number or Rural Route Number, or Town, State)				
	Hosp Housp Fune Fely fil		(Check only 2 Medical Exam	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
	thin 2 the the mplei	Med	one) 29b. Signature and title of certifier	r stated. 29c. License number				29d. Date signed (Month, Dey,			h. Dev. Year)				
	To To					\cap	D 26621				Jan. 23 2004				
								74	Jan. 23 500+						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Common MILLIES 10700 Charles Drive Columbia MD 31. Date filed (Month, Day, Year) 32/Registrar's Signature												
	Sta Registi		FFB 0 3 20	04	a A	& San	18								

An	nend Items 10c,19b per FH,G828,02/03/04dhb Cert	rtment of Health and Mental Fificate of Death	Hygiene Reg. No. 2004 02861						
Physician (Medical	1. Decedent's Name (First, Middle, Last) (Most) es Scott	2. Dete Mon							
/Medical Examiner Funeral Director	4e Fecility Neme (If not institution, give street end number). RIGORNOU MANOR NURS HOME 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Yrs. Usual Residence of Decedent	4b. City, Town, or Location of Control Ville Months Days Hours Min. 8. Date (Months)	Death 4c. County of Death County of Death BOLL Of Birth Ith, Day Year 13-46 9. Birthplace (Stete or Foreign County) MD						
d 21215-0020 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-1 show nit, the Medical Examiner must be notified at the Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Local 10b. Street and Number 1004 Poplar Grove Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	10f. Zip Code 2/2/6 as Decedent of Hispenic Origin? (Specify Yes	10d. Inside City Limits 1 Yes 2 □ No 10g. Citizen of Whet Country? Or No- 14. Race - American Indian,						
0020 hours after ural, or its	3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 No If Yes, Give Year or Dates:	Yes, specify Cuban, Mexican, Puerto Rican, el ☐ Yes 2D No Specify:	Specify: BIACK						
Aaryland 21215-0020 2 should be filed within 72 hours aft 1 and Mentel Hygiens 1 is marked other than "natural", or raumatic event, the Medical Expert To Be Completed by F	15. Decedent's Education (Specify only highest grede completed) Elementary/Secendary (0-12) 17. Fether's Name (First, Middle, Last)	nt's Usual Occupetion ind of work done during most of working DNOT use retired) 18. Mother's Name (First, N	16b. Kind of Business/Industry TRANSPORTATION Middle, Maiden Sumamb)						
Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be flied within 72 hours after death with the Maryle Depertment of Health and Mentel Hygiene. Important: If them 27 is marked other than "natural", or items 23s or 28s-1 sho any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Dunald Rice (Brother) 946 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)	Nichols Drive, 1	Number, City or Town, State, Zip Code) 20707 LAUREL MD 20027 2002. Location - City or Town, State OUT BOHLMURE, MD n Careeru Fundral Six						
ficete be executed ifficete be executed g physician and set the buriel-trensit as the buriel-trensit edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or es e consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
vision of Vital Records, P.O. Box 6 Attending Physician: The lew requires that the death certific or death. ector: After this certificate has been signed by the attending to by the funeral director, page 2 should be deteched for use as iffication: To Be Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the und Hyperteries Arterioschentie Corney Osse	was I wase	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Honknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to						
I Record: The lew require ete has been sig page 2 should I	Dysphasia		completion of cause of death?						
	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Deeth 1 Naturel 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined Could not be determined Leave to building, etc. (Specify)	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No st, factory, office 28f. Loca	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Hospital or 124 hours efte Funeral Dir letely filled in	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stee 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stee 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stee 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stee 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stee 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stee 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stee 1 Certifying Physician: To the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 1 Certifying Physician: To the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause 1 Certifying Physician: To the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause 1 Certifying Physician: To the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause 1 Certifying Physician: To the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause 1 Certifying Physician: To the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause 1 Certifying Physician: To the basis of examination end/or investigation end/or inve								
	29b. Signature end title of certifier **Tacase Currents**	29c. License number	29d. Date signed (Month, Day, Yeer)						
3	39 Name and address of person who completed cause of deeth (Item 23e) (Type, P) (Constant) (Type, P) (Type	they # 508 alex Burn	12061 No. 17d 21061						
State Registrar	31. Dete filed (Month, Day, Year) FEB 0 3 2004 32. Registrer's Signature								

			1 - State of Maryland / State of Maryland /	Department of Health and Mer Certificate of Death	ntal Hygien	ZHHU HZKKZ
	Physic	ion	Decedent's Name (First, Middle, Last)		Date of Death Month Da	ay Year
	/Medi	cal	Chester B. Siatkowski	4b. City, Town, or Location of Death	1 30	2004 5134PM
	Exami	ner	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITA	Rose-11/e		BAITIMORE
	Funeral		5. Social Security Number 0 6. Sex 7. Age (In yrs. last to	birthday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Year	9. Birtholace (State or Foreign
	Director		215-16-7217 ¹™ ^{2□} F 80	Yrs. Ay	or. 10,19	723 Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
	Mary -1 sho	to	Maryland Baltimore	Baltimore		1 ☐ Yes 2 1 No
	ith the Marylan or 28a-f show	irec	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
X	ath wi	ral	4117 Glen Park Rd.	21236		U.S.A. 14. Race - American Indian,
owsk	5-UU30 72 hours after death with the Maryland naturel', or Itams 23a or 28a-1 show licel Exercit at must be incitited at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Ammed Forces? 1 □ Never Married 2 ★ Married 1 ★ Yes 2 □ No	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	an, etc.)	Black, White, etc.
00	urs aff	by	11. Marital Status 1 □ Never Married 2 🕱 Married 3 □ Widowed 4 □ Divorced 1 □ Never Married 2 □ No If Yes, Give WW 11	1 ☐ Yes 2 ☐XNo Specify:		Specify: White
	Z I Z I 3-0U30 sd within 72 hours aff gjene. er than "natural", or tra Medical Everal.	Completed	15. Decedent's Education (Specify only highest grade completed)	5a. Decedent's Usual Occupation (Give kind of work done during most of working	16b.	Kind of Business/Industry
S:4TK	within he had	mp	Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade	Tite. DO NOT use retired) Fork Lift Driver	Amo	erican Standard
	filed Hygie Sther	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maide	n Sumame)
-/ -	lian Jid be Aental rked rtic ev	To Be	Benjamin Siatkowski	Mary	Budzik	
hester	Saltimore, Maryland ZIZID-UU30 sermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. mportant: If tem 27 is marked other than "natural", or Itams 23s or 28s-1 show in yijury or other traumatic event, the Medical Exercite Firmal be notified at ance.	ľ		9b. Mailing Address (Street and Number or Rural R 3012 Tipton Way, Abingd		r or Town, State, Zip Code) 21009
55	or Lealth item 27 I		Three Goods Created the transfer of the transf	of Disposition (Name of Date stery, crematory or other place)		Location - City or Town, State
Ne	nor ages ant of it: If it			oseph Ch. Cem. 2/4/20	04 Ful	lerton, Maryland
U	Baltimory permit. Pages: 1 Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Schim	unek Fun	eral Homes
Ċ	Depa Depa Impo		23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	9705 Belair Rd., Bal		MD 21236 Approximate
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit points.	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) of the conditions of the conditi	ce of):		Onset and Death
	P.O. BOX 68/6U, that the death certificate be eddy the attending physician detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dec 4 ☐ Pregnant at time of death	ath 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
	dS, P uires that signed b Id be dete		Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		o use contribute to the cause of death?
1	Division of Vital Records, at or Attanding Physician: The law requires to after death. I Diractor: After this certificate has been signed in by the funeral director, page 2 should be or	Completed by	Hyper Tension		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
	F Vital F ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (C		
,	Of \OF	2	1 Yes 204-No	Outpatient 3 DOA 4 Nursing Home	5 Residence 1. Describe how inj	6 ☐Other (Specify)
	on on ording Path.: After a funer	ig	27. Manner of Death 1	Injury Work? M 1 ☐ Yes 2 ☐ No		
	DIVISION at or Attending after death. I Director: A d in by the fu	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office 28f	Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
14	To the Hospital or Attanowithin 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowled one) Certifying Physicien: To the best of my knowled and manner stated.			
	To the within To the comp	M	29b. Signature and till certifier	29c. License number		Date signed (Month, Day, Year)
	- (/)		- (- Mye mp	10051014	Jon	nuary 30 2004
	HT		30. Name and address of ferson who completed cause of death (Item 23	la) (Type, Print) SQUARE DR. BATTI		•
	s	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		PERSONAL CA	5, 180 0 /
	Regis	trar	FFR 0 3 2004	Grantes.		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	5	State of	Marylar		epartme Certifica				ntal Hy	giene Reg. No.	200		0286	armond de
			1 Decedent's Name (First, Middle	, Last)							2.	Date of De	ath Day	Ve	er	3. Time of Death	
	Physicia		bessie Sch	ape							J	nuar	2 -			2:35 P	M
	/Medic Examin		4a. Facility Name (If not institution	, give str	eet and nur	nber)		4b. City	, Town, c	r Location	of Deeth		4c.	County of E	Deeth		
			St. Agnes Hegith	care				Box	Him	ore							
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.		Months	er 1 Year Days		Min. 8.	Date of Bi	th ay, Year)	9.	Birthpl Coun	ace (Stete or Fore try)	ign
	Director		213-36-1094	1	4 250 F	6	4 Yr:	S.	<u></u>		Ma	ar. 2	3, 19	39 I	Mary	land	
	p .	}	Usuel Residence of Decedent 10a. State 10b. County			10c. Ci	ity. Town c	or Location							10	d. Inside City Lim	iits
	eho eho	5		-				-								1 ☐ Yes 2√04	No
	28a-f	ect	Maryland Howa:	rd			Elkri		ip Code				10g. Citiz	en of Wha	t Coun	try?	
	death with the Maryland	ä	6188 Old Washin	rton	Road				210	075			Ü	nited	l St	ates	
	leath	era	11. Marital Status		. Was Dece	dent Ever in U	J.S.	13. Was Dec	edent of I	Hispanic O	rigin? (Specify	Yes or N	o- 1	4. Race - /			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Its Modical Examinar must be notified at angle.	by Funeral Director	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ied	Armed Fo 1 Yes If Yes, Giv Year or D	¾ (XNo		If Yes, sp	ecity Cub	an, Mexica	an, Puerto Ric	an, etc.)		Black, V Specify:		ite	
ŏ	2 hou	Completed	15. Deceden				16a. D	ecedent's Us	ual Occup	pation	st of working		16b. Kir	nd of Busin	ess/Ind	lustry	
215	hin 7	pie	(Specify only highe Elementary/Secondary (0-12)	st grade o	College (1	-4or 5+)	- 'ii	ife. DO NOT	use retire	id)	St Of Working						
21;	giene giene gritha	Com	12					Homen	naker	T				n Hon	ne		
5	al Hy I oth	Be (17. Father's Name (First, Middle,	Last)						18. Moti	her's Name (F	irst, Middle	, Maiden	Sumame)			
/lai	Ment Ment arkec	2	Henry Coates								garet E						
a	2 sho and is my		19a. Informant's Name/Relations	hip <i>(Type</i>	e, Print)						ber or Rural R		er, City or	Town, Sta	te, Zip	Code)	
	and ealth m 27		Richard Schape	r - I	Husbar			38 Old		ningt	on Road			e Ma		and 2107	5
ore	ges 1 If ite or ott		20a. Method of Disposition 1 Durial 2 ☐ Cremation	3 □Rei	moval from	State	cemetery,	crematory or	other pla	1					,	•	
턡	Pag tment tant: jury		`4 Donation 5 Dother (S			Me	adowr	ridge N	-		2/4/04		_E1k	ridge	e, M	aryland	_
Baltimore,	Depar Depar Impor any in	8 2	21. Signature of Funeral Service	Licensee				Gary I 7250 V	washi	aufmai ingtoi	n Funer n Blvd.	cal Ho	ome A	t MMF e, Ma	rýl	Inc. and 2107	'5
%			23a. Part1. Enter the disease, of shock, or heart failure. List	complications	ations that o	aused the dea	ath. Do no	t enter the mo	ode of dy	ing, such a	is cardiac or re	spiratory a	arrest,			Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition		muc	xarctia	L	nfanct	ion						(e hoors	
	/Medical		resulting in death)			(or as a conse											
	Examiner	_	Sequentially list conditions,	b.	1511111												
	Sit ad	ine	ri any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Z	D00 10	(or as a sones	queries or	<i>y</i> -									
•	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	С.	Due to	or as a conse	quence of):									
W 8	cate be e. ohysician the buria	aiE		l .													
€87	cate ohy the	dicai		a.						,							
X	certil nding use a	/W	IF FEMALE: 23b. Was decedent pregnant	23		tcome of pregr							1	23d. Date o	if delive	ry	
chaper P.O. Bo	equires that the death certificent signed by the attending tould be detached for use as	Completed by Physician/Me	in the past 12 months?		4☐Pregi	ointh 2 Fernant at time of		3 ☐Ectopic 5 ☐ Other (Month		Day Year	
000	the c	hys	9 □ Unknown		9□ Unkn	own											
2 20	s that ned t	y P	Part II. Other significant conditi	ons cont	ributing to d	eath but not re	sulting in t	the underlying	g cause g	iven in Par	t 1.	23e. Did	tobacco u	se contribu	ite to th	e cause of death?	1
7.75	w equires to been signe should be o	pa p	hyperlipidemi	a								1 🗆	Yes 2	No 3	☐ Prob	abiy 4 □Unkno	iwn
7 48	w 1	olete	hupertension								'	24a. Wa	s an	24b. Wei	re auto	psy findings availa	iple
Recuir	9 H B	mo	tobacco abuse	_									ormed? 2\☑ No	dea	ith? Yes	npletion of cause 2 🕱 No	Çi.
Vital		0	25. Was case referred to medica							26. Pla	ce of Death (0		_/_				
	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Ho	spital:	npatient 2[⊒ ER/Outp	patient 3 1	DOA O	ther: 4 🗆 I	Nursing Home	5 🗆 Res	idence (6 Other	(Specif	1)	
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pendi	0.0	28a. Date (Mor	of Injury th, Day Year)	28b. Tir	me of ury	28c. Inju	ury at ork?	280	d. Describe	how injur	y occurred			
<u> </u>	leath. Ior: Af the fu	atic	2 Accident invest	igation				М	1 [Yes 2							
Division of	ATT de tire de tire clu	Certification;	3 Suicide 6 Could 4 Homicide determ	nined	28e. Place build	a of Injury - At ing, etc. <i>(Spe</i> c	home, farr	m, street, fact	ory, office	•	28f		(Street an own, Stete		or Aura	l Route Number,	
₩ □	spital or ours afton nerel Di filled in	Cel					NEW Y					<u> </u>		ee ce			
	Hosp 4 hou Fune felly fi	edical	(Check only 2 Medica	ng Physi I Examin	er: On the t	e best of my ki	nowledge, nation and	death occurre or investigati	ed at the t on, in my	time, date opinion, d	and place, and eath occurred	at the time	e cause(s) , date and	and mann I place, and	er as s d due to	ated. the cause(s)	
	To the Hospital or Afanding Physiciams within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Med	one) 29b. Signature and title of certific		and mar	ner stated.			29c. Licer	nse numbe	ır		29d. Dat	e signed (/	Month,	Day, Year)	
	M M S		N.O.		, Λ	A			_								
	G_{i}		30. Name and address of person			. MV		(vne Print)	VS	4175			Jan	wan	1 30	, 2004	
60	10		30. Name and address of person	-		Avenu		1301+1	MINITA	-, m	N 211	229					
		ate	31. Date filed (Month, Day, Year			Registrar's Sig		المالي	1101	111	0	00					
	Regist		FFB 0 3	2004			18 1	Seatt 1									
		7			Date of the last o		- State	No.									

DHMH 17 Rev 1/2001

ORIGINAL

	_	LER For State Registrar	State of Mar	•	partment of Fertificate of			leg. No. 2	104	02865
Physicia /Medic		1. Decedent's Name (First, Middle, L Emily A.	Schindler	r			2. Date of Dea Month JAN . 2	Day 200	Year)4	3. Time of Death 4:12 P
Examin	er	4a. Facility Name (If not institution, 9) GARRETT COUNTY	ive street and number) HOSPITAL		4b. City, Town, o OAKLA	r Location of Death VD			ty of Death RETT	
uneral irector			Sex 1 □ M 2 X F	In yrs. last birthda 18 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 2	7 1985	9. Birth Cou Mary	plece (State or Foreign ntry) y land
f ahow		Usual Residence of Decedent 10a. State 10b. County Anne Ar	undel Co.	Oc. City, Town or Pasade	Location na					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
3a or 28a at be notif	I Director	10e. Street and Number 179 Teal Drive			10f. Zip Code 2112	22		10g. Citizen of	What Cou	intry?
Important; I rent 27 is marked offer than the modified Examiner must be notified at once.	by Funeral	11. Marital Status 1	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S. 13	I. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	ВІ	ace - Ameri ack, White, ify: Wh:	
"natur	Completed	15. Decedent's (Specify only highest g	rade completed)	(Gin	sedent's Usual Occup ve kind of work done . DO NOT use retired	eation during most of world)	king	16b. Kind of	Business/Ir	ndustry
I'o M	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		Student			Co1	lege	
avent	Be	17. Father's Name (First, Middle, Last Charles W		chindler		18. Mother's Nam Jane	ie (First, Middle, W.	Maiden Suma	me) Wels!	h
aumatic	10	19a. Informant's Name/Relationship Charles W. Schin	(Type, Print)	19b. Ma	iling Address (Street 79 Teal Dr	and Number or Ru	ral Route Numbe	r, City or Town	n, State, Zij	
othar tr		20a. Method of Disposition		20b. Place of Dis	position (Name of		Date	20c. Location		own, State
ury or	- 1	1 ☐ Burial 2 🖾 Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		Hillton	ematory or other place Service	Corp.01/3	30/2004	Towson	, Md.	
any inj		21. Signature of Funeral Service Lic	ensee	11/1	22. Name and Addre	Polyniak	Funeral	Home	P.A.	1122
100		23a Part 1. Enter the disease, or co shock, or heart failure. List on	mpligations that caused the	ne death. Do not e		ntain Roa ng, such as cardiac			<u>10.</u> Z	Approximate Interval Between
ician dical niner		immediate Cause (Final disease or condition resulting in death)	_aM	whple consequence of):	injuné					Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a	nunsaquenne of):						
ne burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d	consequence of):						
ched for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death	B Ectopic pregnancy	y			late of deliv	very Day Year
been signed by the atte should be detached for	by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	en in Part I.		obacco use co es 2 X Ño		the cause of death?
N	Completed						24a. Was autop perfor 1 🖫 Yes	med?	. Were autoprior to codeath?	opsy findings available ompletion of cause of
rector,	Be	25. Was case referred to medical examiner?	Hospital:	X X X		26. Place of Dea				
funeral di	n: To	1 X Yes 2 □ No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day)		of 28c. Injur	4 🗆 IAUISING II	ome 5 Residence Page 1		ther <i>(Speci</i> urred	
completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 X Accident investigat 3 Suicide 6 Could not determine	ion Jan 27, 20	04 2:40 y · At home, farm,	pM 1□ street, factory, office	Yes 2 (X)No	28f. Location (S City or Tou R 219		nber or Rur	de colliday ral Route Number, Hollow Rd
winn z4 nours arter deain. To the Funeral Director: A completely filled in by the fu	ledical		Physicien: To the best of aminer: On the basis of e	xamination and/or						
o the	Med	29b. Signature and title of certifier	4		29c. Licens	se number		29d. Date sign		, Day, Year) 2004
5		7 0	o completed cause	ath (Item 23a) (Typ	e, Print)					
4 1	4.1	Tashor Z UVER	enbern M.	F 1-	Penn Stree	T Kaltir	Man Ma	maland	-212N	1

		1	For State Registrar	State of Maryland		rtment of H			giene 2	004	02	856
	Physicia	an	Decedent's Name (First, Middle, Last)	C .				2. Date of Dea Month	Day	Year	3. Time of	Death M
	/Medic	al	Riva Latrice	Sa Vacae		4h City Town or	Location of Deat	1 D1	4c Cour	12004 nty of Death	08:3	71 141
14.	Examin	er	4a. Facility Name (If not institution, give si	1 1 1/1 16	buter	0 11.	none			.,		
	Funeral Director		12-61-1266	M 2017	st birthday)Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	h V, Year) 2-03	9. Birth	place (State ontry)	r Foreign
	and	}	Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Loc	ation					10d. Inside Cit	ty Limits
	Maryl -f sho	ō	MA	61	ALTO	51					1 Wes	2 🗌 No
	h with the 3a or 28a at be noti	Funeral Director	10e. Street and Number 4538 PARK	side DV.		10f. Zip Code	06		10g. Citizen	of What Cou	ntry?	
036	be filed within 72 hours after death with the Maryland all Hyglene. Id eithy glene "netural", or items 23a or 28a-f show of other than "netural", or items 23a or 28a-f show event, I're Madical Extending found the notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	. 14. R В Spe	lace - Ameri lack, White, city:		4
21215-0036	within 72 ho iene. r than "netur ine Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give k	ent's Usual Occup ind of work done of O NOT use retired	during most of wo	rking	16b. Kind of	Business/Ir	ndustry	
Maryland 2	should be filed withlind Mental Hygiene. I marked other than umatic event, Ite M	To Be C	17. Father's Name (First, Middle, Last) TIMO Fh	SAVAGE			KiME	me (First, Middle,	Ros	55		
	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic. ance.		19a. Informant's Name/Relatio hip (Typ. Ti'Mo Ho SAV. 20a. Method of Disposition	age FATher	45	Address (Street)	A K5 id	yal Route Nambe e DV Date	20c. Locatio	16 P	74.21	216
altimore,	permit. Pages ' Department of h Important: If ite any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	she l	Name and Address	dens 2	-2-04	DUN	Ap/	K M	11.
Ba	permit. Depart Import any inj		21. Signature of Funeral Service License	The Ar	4	105/2/	polis	Geral	UNER	RAL	16. MA	12031
	Pnysician /Medical		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		Nec	the mode of dyin	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Bett Onset and I	ween
0,	Examiner	Examiner		Due to (or as a conseque	ence of):	Ref	ration	n/				
68760,	cate be physici the bu	dlcal						· · · · · · · · · · · · · · · · · · ·				
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	death 3□	Ectopic pregnancy Other (specify)	/			Date of deliv Month		Year
Ś	uires that the signed by Id be detact	d by Ph	Part II. Other significant conditions con Severe Metabol	tributing to death but not result	ting in the un	derlying cause giv	ren in Part I.	23e. Did to	_/		the cause of d	
Vital Record	The law require ate has been sig page 2 should b	omplete	Respiratory	Failure				24a. Was autop perfor 1 \(\text{Yes} \)	rmed?	prior to co death?	opsy findings ompletion of a	available ause of
/ita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:		aC DOA Oth	oc.	ath (Check only o				
of	Physi this c	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Unpatient 2 LE	PVOutpatient 28b. Time of	3LI DOA	4 🗀 Nursing i	dome 5 Resid			fy)	
ono	ding h. h. After funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injur Wor M 1 🗆	rk? Yes 2 □ No	250. 5030,150	iow injury ood	,u1100		
Division of	if or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tox		mber or Run	al Route Num	ber,
	To the Hospital or Attending Physician: The lawihin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C		sician: To the best of my knowner: On the basis of examination and manner stated.								;)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	- 0		29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)	
,			1 Odora W	mode, MD		1200	06101	8	01/26	1200	4	
			30. Name and address of person who co	impleted cause of death (Item	23a) (Type, F	Print) Adust	ra Won	ode, M	Dani			
	h C1	ato.	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	JVV6 C	, patt	nove,	IVW 2	120			
F	Regist	ate rar	EED 0 9 701	M A	to A	11 A B						

			State of Maryland / Department of H 1 - State Registrar Certificate of		ental Hygien	2001 02067
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	3. Time of Death
	Physici /Media		Robert W. Sichard	į	January 30	
1	Examir		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, C	or Location of Death	40	c. County of Death
				timore If Under 24 Hrs. F	O Data of Birth	N/A
	Funeral Director		1⊠M 2□E Months Days	Hours Min.	8. Date of Birth (Month, Day, Year 2015 10 1	
		1	213-20-7098 81 Yes. Usual Residence of Decedent	<u></u>	Feb. 18, 1	922 Maryland
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-f s	ctor	MD Baltimore Monkton			1 ☐ Yes 2X No
	it to	Dire	10e. Street and Number 10f. Zip Code		10g. C	itizen of What Country?
	ath w	ral		111		USA
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examinat must be notified at once.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent of Netheria (1998) 12 No of Yes, Give Year or Dates:	Hispanic Origin? (Spec pan, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	tural sale		15. Decedent's Education 16a. Decedent's Usual Occup	pation	165.8	Kind of Business/Industry
715	n n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done life. DO NOT use retire	during most of working	9	and or Dubinosa moustry
212	d with giene er the	E O	10 N/A Farmer		Ag	riculture
힏	al Hy 1 oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name ((First, Middle, Maider	n Sumame)
yla	Ment Ment	2	William Sichard	Anna Bank		
Maryland	and and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street			
	1 and Healtl em 27 ther t		Eleanor Bange/Friend 2047 Corbett 20a. Method of Disposition (Name of	t Road Monk		1111 ocation - City or Town, State
Baltimore,	Pages ment of I ant: If It ury or o	-	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) **Cemetery Crematory or other pla Western Cemetery	Feb. 4	4,	altimore, MD
Balt	permit. Departimport any inj		21. Signature of Funeral Service Drensee 22. Name and Addre Lemmon Fun 10 W. Pado	eral Home	of Dulane	y Valley, Inc. MD 21093
8760,	death certificate be executed [Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical	ilcai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the conditions of the	Forder		Approximate Interval Batween Onset and Death
P.O. Box 6	death certif e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)	у		23d. Date of delivery Month Day Year
	The law requires that the ate has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gre	ven in Part I.	23e. Did tobacco	use contribute to the cause of death?
Sor	v requ	etec				
Division of Vital Records,	The lav	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vita	icien: sertific ector.	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (
ot	Phys this al dir	٠ <u>۲</u>	1 Inpatient 2 ER/Outpatient 3 DOA		e 5 ☐ Residence	
CO	ding h. Alter fune	tion	1 Natural 5 Pending (Month, Day Year) Injury Wor	rk?]Yes 2 □No	d. Describe how inju	ry occurred
ivisio	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: Alter this certificate ha completely filled in by the funeral director, page	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined willding, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		f. Location (Street ar City or Town, State	nd Number or Rural Route Number,
	To the Hospitel (within 24 hours a To the Funeral Completely filled in		29a. Certifier (Check only 29a. Medical Examiner: On the basis of examination and/or invastigation in my of	me, date and place, an	d due to the cause(s) and manner as stated.
	the H in 24 the F iplete	Medical	one) and manner stated.			
	To with	Σ	29b. Signature and title of certifier D 29c. Licens D 3	Sly64	29d. Da	te signed (Month, Day, Year)
	18		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOALLS A HASKEN S2(N, Endo	nw of	Sinte 3	108, Bell MD 2120
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			, , , , , , , , , , , , , , , , , , , ,
DH	Registr		FEB 0 3 2004			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🔿 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2004 **Physician** January 11:55 A™ Esther Mae Simmons /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Dulaney Towson Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day, 9. Birthplece (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1908 1□ M 2 1 F June 6. 235-32-3882 95 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Itama 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore MD Towson 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21204 USA 111 West Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 Å No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other than sny injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event injury or other event injury or oth Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Metta L. Sullivan John L. Garey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) granddaughter 12309 Happy Hollow Rd: Cockeysville, MD 21030 Patricia <u>Ann Parrish</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Pine Grove 2/1/04 Berea, WV * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1050 York Road 21. Signature eran Service Ruck Towson Funeral Home Towson, MD 21204 Orn at caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 Ø No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ⊠Unknown cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 Yes 2₺ No 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 2 ER/Outpatient 3□ DOA Certification: To Sign 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deal To the Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide tag Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 53642 30. Name; and address of person who completed cause of death (Item 23a) (Type, Print) och Raven Blue 303 1ACLITUU 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State 2004 Registrar

South

			1 - For State Registrar	State of Maryland		artment rtificate					Reg. No.	1 3 1 7 1	4 0287	Constant of the Constant of th
	Physici /Medic		1. Decedent's Name (First, Middle, Last)					LES		2. Date of De Month JANUA	ath RY Day	27 °2	3. Time of Death 12: 46 P	V
- A	Examir	er	4a. Facility Name (If not institution, give s HARBOR HOSP/71	AL CENTER			LT11	Location o	E			County of D	A	
Ċ	Funeral Director		5. Social Security Number 090 38 9844 Usual Residence of Decedent	7. Age (In yrs. Ia 3 M 2 F 56	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da July 2	y, Year)	947	Birthplace (State or Foreig Country) New York	
	a-f ehow	ctor	10a. State 10b. County Maryland Anne Ar		Town or Lo .en Bu								10d. Inside City Limit 1 ☐ Yes 2 🔀 N	
	h with th	ai Dire	10e. Street and Number 408 Wooded Lake	Court		10f. Zip	210	061			-	zen of What U.S.A	•	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f ehow any injury or other traumettic event, the Modified Examination to the modified at ADES.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:		Was Decede		spanic Origin, Mexican,	gin? (Spec , Puerto F	cify Yes or No tican, etc.)	-		Merican Indian, White, etc. White	
21215-0036	vithin 72 ho	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	(Give life. i	dent's Usual kind of work DO NOT use	Occupa k done d e retired)	tion uring most	of workin	g		nd of Busine	ess/Industry	
Maryland 2	uld be filed v fental Hygie rked other t lic event, th	To Be Co	17. Father's Name (First, Middle, Last) unknown	2 years	_ casi	hier			r's Name nknow	(First, Middle,		Sumame)		_
Mary	th and N		19a. Informant's Name/Relationship (Type Mai Filer	pe, Print)		ng Address Elizab				Route Numbe	-		e, <i>Zip Code)</i> 1and 21061	
Baltimore,	ages 1 ar int of Hea t: If item:		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	netery, crer	osition (Naminatory or oti	her place			ite	20c. Lo	cation - City	or Town, State	
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service License		22	2. Name and	Addres:	s of Facility	eorg	e J. Go	once	Funer	e, Maryland Tal Home, P. Aryland 2122	A •
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. le cause on each line. LIVER Due to (or as a conseque	Do not ent	er the mode	of dying	, such as o	cardiac or	respiratory a	rest,		Approximate Interval Between Onset and Death	
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	RENAL P Due to (or as a conseque RESPIRATO)			UDE						1 a days.	
8760,	sate be executed obysician and the burial-transit	ilcai Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ance of):				2 B	LEEDY	V4		3 days	
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed redeath. crosath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3□	Ectopic pre Other (spe					2	3d. Date of Month	delivery Day Year	
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	atributing to death but not result	ting in the u	nderlying ca	use give	n in Part I.			obacco u res 28		e to the cause of death? Probably 4 DUnknown	n
al Records,	: The law recate has bee page 2 sho	Completed								24a. Was autop perfo 1 Yes	sy rmed?	24b. Were prior death	autopsy findings available to completion of cause of ??	8
Vita	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	R/Outpatien	nt 3□ DO/	Othe			(Check only o		Other (S	inecify)	100
Division of Vital	nding Physician: The lith. ith. :: After this certificate ha e funeral director, page		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury		c. Injury Work		28	3d. Describe			poorty)	
Divis	i gitte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory,	office		28	3f. Location (5 City or Tox	Street and vn, State)	d Number or	Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my knowner: On the basis of examination	ledge, death on and/or inv	n occurred a vestigation,	t the time in my op	e, date and inion, deat	d place, ar h occurre	nd due to the d d at the time,	cause(s) date and	and manner place, and o	as stated. due to the cause(s)	
	To the within ? To the comple	Me	29b. Signature and title of certifier	- Medica Doch	l 0 × ·	29c	cense	number 778	5		29d. Date JAN (signed (Ma	27, 2004	
			30. Name and address of poon who co	420		Print) NOVE	RS	57,	BAG	Timo			21225	
. 1	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 3 2004	32. Registrar's Signatu		doa	Har	}						

huciai	28	Decedent's Name (First ROSA	t, Middle, Last)		c	SAKS				Date of Deat Month	th Day	Year	3. Time of Death
hysici: /Medic						DAKS	T			pour	23	2001	
min	er	4a. Facility Name (If not in	11/1/	1 1 0	14.		4b. City, Tow	n, or Location	of Death		N/A	unty of Dea A	atn
al		5. Sociel Security Number	110 110	01 DT 0	e (In yrs.	last birthday	If Under 1 Ye		24 Hrs. 8. C	ate of Birth			rthplace (State or Forei
		213-30-661		M 2016	78	last birthday Yrs.	Months Da	ys Hours	Min.	rotti, Day	9×04/92	5 PG	EMANU
		Usual Residence of Dece			Tago Cit	y, Town or L	anation.						10d. Inside City Limit
,	5		County ALTIMOR	RE		TIMOR							1 DYes 2DN
Funeral Director		10e. Street and Number					10f. Zip Coo	le .		1	0g. Citizen	of What C	country?
Ē	5	2839 MARNAT	ROAD				21208				JŠA		
200	<u> </u>	11. Marital Status		12. Was Decedent	Ever in U	.S. 13.	Was Decedent If Yes, specify (of Hispanic Or	igin? (Specify	Yes or No-	14.	Race - Am Black, Whi	erican Indian,
Fu F	-	1 Never Married 2		Armed Forces 1 ☐ Yes 2 🔀	No		1 ☐ Yes 2 🕅			, 0.0.,			HITE
7	d Dy	3 🎖 Widowed 4 □ D		If Yes, Give Year or Dates:									
lote		15. D (Specify only	ecedent's Edu y highest grade	cation e <i>completed)</i>		(Giv	dent's Usual Oc kind of work do DO NOT use re	one during mo	st of working		16b. Kind	of Business	s/Industry
Completed	-	Elementary/Secondary	(0-12)	College (1-4or	5+)	MANA					CLOTH	ING	
		17. Father's Name (First,	Middle, Last)					18. Moth	er's Name (Fir	st, Middle, i	Maiden Sui	mame)	ojra Powidla
l	To Be	BERNARD		HELM	IAN			DEVO)RAH		POWII	DLA_DW	Ojia rowitila
		19a. Informant's Name/R	elationship (Ty	rpe, Print)		19b. Mail	ng Address (Str	eet and Numb	er or Rural Ro	ute Number	r, City or To	own, State,	Zip Code)
		MRS. DEBORA	H/FRIED	DMAN/DAUG			DARW00						
		20a. Method of Disposition 1 □ Burial 2 □ Crer		Removal from State	1 6	Place of Disp	osition (Name o	place) T	Date				r Town, State
		* 4 □Donation 5 □ C	Other (Specify)		(1)		ID) CON		1/26/20			ALE,M	
		21. Signar n of Funeral	Service Licens	99			2. Name and Ad						
		Juy W	aup	li	d the deat	8	900 REI	STERST(OWN ROA	DPIKE:	SVILL	E,MD.	21208 Approximate
		23a. Part . Enter the disc shack, of heart failu Immediate Cause (Final	ire. List only or	ne cause on each	line.	ii. Do not ei	rei tile iliooe oi	dying, such as	s cardiac or res	phatory and	631,		Interval Between Onset and Death
		disease or condition resulting in death)		. Uros	epsi	5							3 days
				Due to (or a	s a conseq	(Luence of):	.51						da
	e	fany, leading to immedia cause. Enter Underlying Cause (Disease or injury	ate t	Due to (or a	s a conseq	juence of):	wro						
	듣	Cause (Disease or injury	1										
1		that initiated events											
	Examiner	that initiated events resulting in death) Last		Due to (or a	s a conseq	juence of):							
	cal	that initiated events		Due to (or a	s a conseq	quence of);							
	cal	resulting in death) Last		d									
	cal	resulting in death) Last IF FEMALE: 23b Was decedent pregr	namt	d 23c. If yes, outcom	e of pregna 2 ☐ Feta	ancy	□Ectopic pregn				23d	. Date of de	elivery Day Year
	cal	resulting in death) Last	namt	d	e of pregna 2 ☐ Feta	ancy	□Ectopic pregn: □ Other (specif)				23d		
	Physician/Medical	IF FEMALE: 23b Was decedent pregint the past 12 month	nant ns?	d	e of pregna 2 Feta at time of d	ancy at death 3 death 5	Other (specify		1.	23e. Did toi		Month	
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 No 9 Unknown	nant ns?	d	e of pregna 2 Feta at time of d	ancy at death 3 death 5	Other (specify		I.	23e. Did toi	bacco use	Month contribute	Day Year
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 No 9 Unknown	nant ns?	d	e of pregna 2 Feta at time of d	ancy at death 3 death 5	Other (specify				bacco use	Month contribute	Day Year to the cause of death? Probably 4 □Unknov
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 No 9 Unknown	nant ns?	d	e of pregna 2 Feta at time of d	ancy at death 3 death 5	Other (specify			1 ☐ Ye 24a. Was a autops perfori	bacco use es 2 \sqrt{n}	Month contribute to the second secon	Day Year to the cause of death? Probably 4 Unknow autopsy findings available completion of cause of
	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 No 9 Unknown Part II. Other significant ALLAELE AMERICA	conditions con	d	e of pregna 2 Feta at time of d	ancy at death 3 death 5	Other (specify	given in Part		1 Ye 24a. Was a autops perfori 1 Yes	bacco use es 2 10 N un 2 sy med? 2/10 No	Month contribute No 3 F	Day Year to the cause of death? Probably 4 Unknow autopsy findings available completion of cause of
	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 No 9 Unknown	conditions con medical	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown ntributing to death	e of pregna 2 Feta at time of d	ancy at death 3 death 5 sulting in the	☐ Other (specify	26. Plac	e of Death (Ch	1 You	bacco use es 2 0 n in 2 in 2 in 2 in 2 in 2 in 2 in 2 in	Month contribute No 3 F 4b. Were a prior to death? 1 Ye	Day Year to the cause of death? Probably 4 Unknov autopsy findings availat o completion of cause o
The state of the s	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregress to the past 12 month 1 Yes 2 No 9 Unknown Part II. Other significant A LABEL 25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death	conditions co	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown ntributing to death	e of pregna 2 Fetatat time of d but not res	ancy al death 3 leath 5 sulting in the	Other (specify	26. Plac	e of Death (Ch	1 You 24a. Was a autops perform 1 Yes	bacco use es 2 \(\sigma \) in 2 sy med? 2 \(\sigma \) No ence 6	Month contribute No 3 F 4b. Were a prior to death; 1 Ye	Day Year to the cause of death? Probably 4 Unknov autopsy findings availat o completion of cause o
	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnin the past 12 month 1	conditions conditions	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown ntributing to death	e of pregna 2 Fetatat time of d but not res	ancy If death 3 death 5 sulting in the	Other (specify underlying cause ont 3 DOA of 28c.	26. Plac	te of Death (Chursing Home 28d.	1 Yes 24a. Was a autops perfori 1 Yes 10ck only on	bacco use es 2 \(\sigma \) in 2 sy med? 2 \(\sigma \) No ence 6	Month contribute No 3 F 4b. Were a prior to death; 1 Ye	Day Year to the cause of death? Probably 4 Unknov autopsy findings availat o completion of cause o
	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregin the past 12 month 1	conditions conditions conditions conditions	23c. If yes, outcom 1 Live brith 4 Pregnant 9 Unknown htributing to death 1 Inpal 28a. Date of in (Month, D	e of pregna 2 Feta at time of d	ancy ald death 3 death 5 sulting in the BER/Outpatit 28b. Time	Other (specify underlying cause ont 3 DOA of 28c.	26. Plac Other: 4 N Injury at Work? 1 Yes 2	ursing Home 28d.	1 Yes 24a. Was a autops perform 1 Yes Beck only on 5 Reside	bacco use es 2 \(\sigma \) in sy med? 2 \(\sigma \) No ence 6 \(\sigma \) ow injury or	Month contribute to a Tender to the contribute of the contribute	Day Year to the cause of death? Probably 4 Unknov autopsy findings availat o completion of cause o
	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregrin the past 12 month 1 Yes 2 No 9 Unknown Part II. Other significant A. W. W. W. W. W. W. W. W. W. W. W. W. W.	medical Pending investigation Could not be determined	B3c. If yes, outcom 1	e of pregna 2 Feta at time of combut not resident 2 ury ary Yeer)	ancy at death 3 death 5 sulting in the BER/Outpatit 28b. Time Injury ome, (arm, s	Other (specify underlying cause ant 3 DOA of 28c. M treet, factory, off	26. Plac Other: 4 N Injury at Work? 1 Yes 2	ursing Home 28d.	1 Yes 24a. Was a autops perform 1 Yes Beck only on 5 Reside Describe he	bacco use es 2 \(\sigma \) n sy med? 2 \(\sigma \) ence 6 \(\sigma \) ow injury or treet and N n, State)	Month contribute I do 3 F 24b. Were a prior to death? 1 Ye Courred	Day Year to the cause of death? Probably 4 Unknov autopsy findings availat completion of cause of us 2 No ecify) Rural Route Number,
	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent preginthe past 12 month 1	medical Pending investigation Could not be determined Certifying Phy	d	e of pregna 2 Feta at time of comment 2 Lawry ay Yeer) and Yeer At he comment of examina to finy known of examina to finy known of examina to finy known of examina to finy known to finy known of examina to finy known to finy	ancy at death 3 death 5 sulting in the BER/Outpatie 28b. Time Injury ome, farm, s	Other (specify underlying cause and 3 DOA of 28c. M	26. Plac Cther: 4 N Injury at Work? 1 Yes 2 Cice	ursing Home 28d. No 28f.	1 Yes 24a. Was a autops perform to the control of	bacco use es 2 \(\sigma \) n sy med? 2\(\sigma \) ne) ence 6 \((\sigma \) ow injury or treet and \(N \) n, \(State \) ause(s) an	Month contribute lo 3 F 4b. Were a prior to death? 1 Ye Other (Sp) ccurred	Day Year to the cause of death? Probably 4 Unknow autopsy findings availat b completion of cause of as 2 No ecity) Rural Route Number, as stated.
	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregrent the past 12 month 1	medical Pending investigation Could not be determined Certifying Phy Medical Exami	d	e of pregna 2 Feta at time of comment 2 Lawry ay Yeer) and Yeer At he comment of examina to finy known of examina to finy known of examina to finy known of examina to finy known to finy known of examina to finy known to finy	ancy at death 3 death 5 sulting in the BER/Outpatie 28b. Time Injury ome, farm, s	ont 3 DOA of 28c. M treet, factory, off	26. Plac Cther: 4 N Injury at Work? 1 Yes 2 Cice	ursing Home 28d. No 28f.	1 You 24a. Was a autops perform 1 Yes leck only on 5 Reside Describe he Location (S) City or Town due to the ct the time, d	bacco use es 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month contribute I o 3 F th. Were a prior to death? 1 Ye Other (Sp. courred	Day Year to the cause of death? Probably 4 Unknov autopsy findings available completion of cause of the cau
	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent preginthe past 12 month 1	medical Pending investigation Could not be determined Certifying Phy Medical Exami	d	e of pregna 2 Feta at time of comment 2 Lawry ay Yeer) and Yeer At he comment of examina to finy known of examina to finy known of examina to finy known of examina to finy known to finy known of examina to finy known to finy	ancy at death 3 death 5 sulting in the BER/Outpatie 28b. Time Injury ome, farm, s	ont 3 DOA of 28c. M treet, factory, off	26. Plac Other: 4 N Injury at Work? 1 Yes 2 Cice The time, date any opinion, de	ursing Home 28d. No 28f.	1 You 24a. Was a autops perform 1 Yes leck only on 5 Reside Describe he Location (S) City or Town due to the ct the time, d	bacco use es 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month contribute I o 3 F th. Were a prior to death? 1 Ye Other (Sp. courred	Day Year to the cause of death? Probably 4 Unknow autopsy findings availat b completion of cause of as 2 No ecity) Rural Route Number, as stated.
	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregrent the past 12 month 1	medical Pending investigation Could not be determined Certifying Phy Medical Exami	B3c. If yes, outcom 1 Live birth 4 Pregnant: 9 Unknown antributing to death 1 Inpat 28a. Date of In (Month, D 28e. Place of It building, 6 sician: To the basis and manners	e of pregna 2 Feta at time of comments 2 Feta at time of comments 2 Feta at time of comments 2 Feta at time of comments 2 Feta at time of examination at the comments 2 Feta at the com	ancy aldeath 3 death 5 sulting in the BER/Outpatit 28b. Time Injury ome, farm, s fy) owledge, deation and/or i	ont 3 DOA of 28c. M treet, factory, off th occurred at the occ	26. Plac Other: 4 N Injury at Work? 1 Yes 2 Cice The time, date a The proposition of the circle.	ursing Home 28d. No 28f.	1 You 24a. Was a autops perform 1 Yes leck only on 5 Reside Describe he Location (S) City or Town due to the ct the time, d	bacco use es 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month contribute I o 3 F th. Were a prior to death? 1 Ye Other (Sp. courred	Day Year to the cause of death? Probably 4 Unknov autopsy findings available completion of cause of the cau

Physician Aa E Physician A	ABRAHAM SNYDER ABRAHAM SNYDER ABRAHAM SNYDER ABRAHAM SNYDER ABRAHAM SNYDER ABRAHAM SNYDER ABRAHAM SNYDER ABRAHAM SNYDER ABRAHAM SNYDER ABRAHAM SNYDER ABRAHAM SNYDER BUT ABRAHAM SNYDER ABRAHAM SNYDER BUT ABRAHAM SN	Street and number) HOME IX	95 Yrs. 96 Yrs. 97 Yrs. 98 Yrs. 98 Yrs. 98 ALT 98 ALT 99 In June 10 Alternative of Disport o	BALTIM BALTIM	21209 Hispanic Origin? (Speath, Mexican, Puerto Specity: Day Book KEEPE 18. Mother's Name RACHE 18. Mother's Name RACHE 18. Mother's Name RACHE 18. Mother's Name RACHE 18. Mother's Name RACHE 18. Mother's Name RACHE 18. Mother's Name RACHE 18. Mother's Name RACHE 18. Mother's Name RACHE 2 (2) (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	8. Date of Birth MAR. 20, 19 8. Date of Birth MAR. 20, 19 10g. 10g. 10g. 16b. 16b. 16c.	4c. County of Deet 9. Birth Co 14. Race - Ame Black, White Specify: D. Kind of Business/ EDUCATION den Sumame)	N/A hplace (State or Foreignerity) MD 10d. Inside City Limit 1 □ Yes 2 ☑ N untry? U.S.A. rican Indian, e, etc. WHITE industry SNITZ Zip Code) Town, State
Medical Examiner The marked other than and Mental Hyglene. The marked other than and mental Hyglene. The marked other than and mental the marked other than and mental than 27 la marked other than and mental than 27 la marked other than and mental than 27 la marked other than and mental than 27 la marked other than and mental than 27 la marked other than and mental than 27 la marked other than and mental than 27 la marked other than and mental than 27 la marked other than and mental than 27 la marked other than and mental than 27 la marked other than and mental than 27 la marked other than 28 la m	Fecility Name (If not institution, give LEVINDALE HEBREW Social Security Number 213-01-6561 Jel Residence of Decedent a. State 10b. County MD BALTI b. Street and Number 2410 SYLVALE ROAD Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edit (Specify only highest grade) Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Last) SAMUEL a. Informant's Name/Relationship (T) ABRAHAM SNYDER A. Method of Disposition 1 Mauriel 2 Cremation 3 Dividence of Funeral Service Licenses Signature of Funeral Service Licenses Sal Pert 1. Enter the discussion of the companion o	HOME TOME	95 Yrs. 96 Yrs. 97 Yrs. 98 Yrs. 98 Yrs. 98 ALT 98 ALT 99 In June 10 Alternative of Disport o	Ab. City, Town, BALTIM BALTIM If Under 1 Year Months Days Ocation IMORE 101. Zip Code Was Decedent of If Yes, specify Cul 1 Yes, specify Cul 2 Note of Work done BONCT use retire RETARY / RBECK ing Address (Stree D SYLVALE osition (Name of ormatory or other pic E HEBREW 12. Name and Address.	AORE To lift Under 24 Hrs. So Hours Min. 21209 Hispanic Origin? (Sphan, Mexican, Puerto of Specify: Upation BOOKKEEPE 18. Mother's Namerical RACHE 18. Mother's	8. Date of Birth MAR. 20, 19 10g. Decify Yes or No- Prican, etc.) 16b R R In (First, Middle, Maid L ALTIMORE, Date 20c	4c. County of Deet 9. Birth 218 9. Birth Co 14. Race - Ame Black, White Specify: b. Kind of Business/ EDUCATION den Sumame) ity or Town, State, 2 MD 21209 b. Location - City or	N/A hplace (State or Fore unitry) MD 10d. Inside City Lim 1 Yes 2 1 1 untry? U.S.A. rican Indian, e, etc. WHITE industry SNITZ Zip Code) Town, State
To Be Completed by Funeral Director To Be Compl	213-01-6561 Juli Residence of Decedent A. State 10b. County MD BALTI BALT	IMORE 12. Was Decedent Ever Armed Forces? 1	85 Yrs. Oc. City, Town or Lot BALT er in U.S. 13. 16a. Dece (Give life. SECF) OVER 19b. Mailit 2410 20b. Place of Disporterly, cre. BALTIMORE	Months Days ocation FIMORE 101. Zip Code Was Decedent of it Yes, specify Cult 1 Yes 2 Note address Usual Occur a kind of work done DO NOT use retire RETARY / RBECK ing Address (Stree D SYLVALE osition (Name of pinatory or other pic E HEBREW 12. Name and Address (Stree 23. Name and Address (Stree 24. Name and Address (Stree 25. Name and Address (Stree Control (Name of pinatory or other pic Control (Name of pinatory or other pic Control (Name and Address)	21209 Hispanic Origin? (State of the stand Number or Ruce of Road) 18. Mother's Name of the stand Number or Ruce of Road - Base) 18. Mother's Name of the stand Number or Ruce of Road - Base) 18. Mother's Name of the stand Number or Ruce of Road - Base of Road - Base of Road - Base of Road - Base of Road - Base of Road -	MAR. 120, 16 MAR. 120, 16 10g. 10g. 16b. 16b. 16b. 16b. 16c. 16	Citizen of What Co 14. Race - Ame Black, White Specify: D. Kind of Business/ EDUCATION den Sumame) ity or Town, State, 2 MD 21209 D. Location - City or Town	Industry Indust
an and mile transit miportant: If Item 27 is marked other than "natural", or Items 23s or 28s-f show inia-transit and initial control of the Medical Examiner must be notified at any injury or other treumatic event, the Medical Examiner must be notified at any injury or other treumatic event, the Medical Examiner and injury or other treumatic event, the Medical Examiner and injury or other treumatic event injury	A. State 10b. County MD BALTI BALTI B. Street and Number 2410 SYLVALE ROAD Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grace) Elementary/Secondary (0-12) Father's Name (First, Middle, Last) SAMUEL a. Informant's Name/Relationship (T. ABRAHAM SNYDER / B. Method of Disposition 1 Maurial 2 Cremation 3 Divided A Donation 5 Other (Specify, Signature of Funeral Service Licens) Ba. Pert 1. Enter the discussion of the composition of the country of the countr	I MORE 12. Was Decedent Ever Armed Forces? 1 Yes 2 00 No If Yes, Give Year or Dates: ucation To completed) College (1-4or 5+) Y HUSBAND Removal from State	BALT er in U.S. 13. 16a. Dece (Give iffe. SECR OVER 19b. Maili 2410 20b. Place of Dispo completery, cre. BALTIMORE	Was Decedent of If Yes, specify Cult Yes, specify Cult Under Section 1 Yes 2 Note of the North Yes 2 Note of the North Yes 2 Note of the North Yes 2 Note of the North Yes 2 N	Hispanic Origin? (St. ban, Mexican, Puerto Specify: Upation e during most of worked) BOOKKEEPE 18. Mother's Nam RACHE at and Number or Ru. E ROAD - B	Decity Yes or No- Decity Yes o	14. Race - Ame Black, White Specify: D. Kind of Business/I EDUCATION den Sumame) ity or Town, State, 2 MD 21209 D. Location - City or	untry? U.S.A. inician Indian, e, etc. WHITE Industry SNITZ Sip Code) Town, State
Examiner Taxaminer Taxaminer To Be Completed by Funeral Direct Hamaning and Line Residues and Line	2410 SYLVALE ROAD Marital Status Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates: ucation de completed) College (1-4or 5+)	or in U.S. 13. 16a. Dece (Give life). SECF OVER 19b. Maili 2410 20b. Place of Disport cometery, cre. BALTIMORE	Was Decedent of If Yes, specify Cul I Yes, specify Cul I Yes 2 No No Not use retire RETARY / RBECK ing Address (Stree D SYLVALE osition (Name of matory or other pic HEBREW 12. Name and Address (Address Stree D SYLVALE osition (Name of matory or other pic HEBREW 12. Name and Address (Stree D SYLVALE osition (Name of matory or other pic HEBREW 12. Name and Address (Stree D SYLVALE osition (Name of matory or other pic HEBREW 12. Name and Address (Stree D SYLVALE OSITION (Name of Matory or other pic HEBREW 12. Name and Address (Stree D SYLVALE OSITION (Name of Matory or other pic SYLVALE OSITION (Name o	Hispanic Origin? (St. ban, Mexican, Puerto Specify: Upation e during most of worked) BOOKKEEPE 18. Mother's Nam RACHE at and Number or Ru. E ROAD - B	Decity Yes or No- Decity Yes o	14. Race - Ame Black, White Specify: D. Kind of Business/I EDUCATION den Sumame) ity or Town, State, 2 MD 21209 D. Location - City or	untry? U.S.A. rican Indian, e, etc. WHITE Industry SNITZ Tip Code)
ician disadical niner Sec and a cau cau cau cau cau cau cau cau cau c	Marital Status Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1	16a. Dece (Give life. SECR OVER 19b. Maili 2410 20b. Place of Disper competery, cre BALTIMORE	Was Decedent of If Yes, specify Cult 1 Yes, specify Cult 1 Yes 2 Not seem of work done of work done of work done of work done of work done of work done of the control of t	Hispanic Origin? (St. ban, Mexican, Puerto Specify: Upation e during most of worked) BOOKKEEPE 18. Mother's Nam RACHE at and Number or Ru. E ROAD - B	Decity Yes or No- Decity Yes o	14. Race - Ame Black, White Specify: D. Kind of Business/I EDUCATION den Sumame) ity or Town, State, 2 MD 21209 D. Location - City or	U.S.A. rican Indian, e, etc. WHITE industry SNITZ Zip Code) Town, State
sician discount disco	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edit (Specify only highest grace) 16. Decedent's Edit (Specify only highest grace) 17. Pather's Name (First, Middle, Last) SAMUEL a. Informant's Name/Relationship (T. ABRAHAM SNYDER / ABRAHAM SNYDER / ABUT (Specify) a. Method of Disposition 1 Maurial 2 Cremation 3 1 1 Maurial 2 Cremation 3 1 Maurial 2 Cremation 3 1 Maurial 2 Cremation 3 1 Maurial 2 Cremation 3 1 Maurial 2 Maurial 2 Maurial 2 Maurial 2 Maurial 2 Maurial 2 Maurial 3 Maurial 2 Maurial 3 Mau	Armed Forces? 1	16a. Dece (Give life. SECR OVER 19b. Maili 2410 20b. Place of Disper competery, cre BALTIMORE	adent's Usual Occue e kind of work done DO NOT use retire RETARY / RBECK ing Address (Stree D SYLVALE osition (Name of ematory or other pic E HEBREW 12. Name and Address	pation e during most of worked) BOOKKEEPE 18. Mother's Name RACHE at and Number or Rule E ROAD - B	king 16b R I I De (First, Middle, Maid L ral Route Number, Ci SALTIMORE, Date 200	Black, White Specify: b. Kind of Business/ EDUCATION den Sumame) ity or Town, State, 2 MD 21209 b. Location - City or 1	SNITZ Sip Code) Town, State
cian discal intermentation in the cian discal intermentation in the cian discal	(Specify only highest grace (Specify only highest grace) 12 Father's Name (First, Middle, Last) SAMUEL a. Informant's Name/Relationship (The ABRAHAM SNYDER / Americal Survice License) a. Method of Disposition 1 X Burial 2 Cremation 3 14 Donation 5 Other (Specify, Signature of Funeral Service License) ba. Pert 1. Enter the dissue, or composhock, or heart failure. List only of mediate Cause (Final sease or condition)	College (1-4or 5+) Cype, Print) / HUSBAND Removal from State)	OVER 19b. Maili 2410 20b. Place of Disporterly, cres BALTIMORE	RETARY / RETARY / RETARY / RETARY / RECK ing Address (Stree D SYLVALE osition (Name of ematory or other pic E HEBREW 12. Name and Address Add	BOOKKEEPE 18. Mother's Nam RACHE at and Number or Ru. E ROAD - B	R In In In In In In In In In In In In In	EDUCATION den Sumame) ity or Town, State, 2 MD 21209 c. Location - City or	SNITZ Zip Code) Town, State
ician disadical niner Sec and a cau cau cau cau cau cau cau cau cau c	Father's Name (First, Middle, Last) SAMUEL a. Informant's Name/Relationship (T. ABRAHAM SNYDER / a. Method of Disposition 1 & Burial 2 Cremation 3 1 4 Donation 5 Other (Specify, Signature of Funeral Sarvice Licens ba. Pert 1. Enter the dissue, or compshock, or heart failure. List only comediate Cause (Final sease or condition	ype, Print) / HUSBAND Removal from State)	OVER 19b. Maili 2410 20b. Place of Disponementary, cres BALTIMORE	RBECK ing Address (Stree D SYLVALE omatory or other pla E HEBREW 12. Name and Addr	18. Mother's Nam RACHE et and Number or Ru. E ROAD - B lace) CEM. 2/1/	The (First, Middle, Main Land Route Number, Cit ALTIMORE, Date 20c	ity or Town, State, 2 MD 21209 b. Location - City or	SNITZ Eip Code) Town, State
cian discal intermentation in the cian discal intermentation in the cian discal	SAMUEL a. Informant's Name/Relationship (T. ABRAHAM SNYDER / a. Method of Disposition 1	HUSBAND Removal from State	2410 20b. Place of Disponsional	osition (Name of matory or other place HEBREW Name and Address (Street)	RACHE The and Number or Rule ROAD - B The ace) CEM. 2/1/	ALTIMORE, Date 20c	ity or Town, State, 2 MD 21209 Location - City or	Zip Code) Town, State
ician discussion and	ABRAHAM SNYDER a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify, Signature of Funeral Sarvice Licens ba. Pert 1. Enter the dissue, or compshock, or heart failure. List only of mediate Cause (Final sease or condition	HUSBAND Removal from State	2410 20b. Place of Dispo cometery, cre BALTIMORE	O SYLVALE osition (Name of smatory or other pla E HEBREW 12. Name and Addr	E ROAD - B	ALTIMORE,	MD 21209	Town, State
cian discal intermentation in the cian discal intermentation in the cian discal	1 M Burial 2 Cremation 3 1 4 Donation 5 Other (Specify, Signature of Funeral Service Licens Ba. Pert1. Enter the disse, or compshock, or heart failure. List only of mediate Cause (Final sease or condition	Removal from State) see	BALTIMORE	E HEBREW 22. Name and Addr	CEM. 2/1/			
ician disadical niner Sec di a cau cau cau that result that result had result	A Donation 5 Other (Specify, Signature of Funeral Service Licens Ba. Pert1. Enter the disse, or compshock, or heart failure. List only of mediate Cause (Final sease or condition	see	23	2. Name and Addr		2004	REISTERST	ULINE MED
ician discussion and	da. Pert1. Enter the dissue, or comp shock, or heart failure. List only of mediate Cause (Final sease or condition		8			I LEVINCO		
iner Section discrete that the trees the trees the trees the trees that the trees	mediate Cause (Final sease or condition	blications that caused thone cause on each line.				L LEVINSON ROAD - PIN		
	sulting in death) equentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last	a. Due to (or as a c Due to (or as a c Due to (or as a c	consequence of):	iter the mode of dy	ring, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Sic	FEMALE: b. Was decedent pregnant in the past 12 months?	d	pregnancy	□Ectopic pregnanc	су		23d. Date of deli	ivery Day Year
, g	1 Yes 2 No	4 ☐ Pregnant at tim 9 ☐ Unknown	ne of death 5L	Other (specify)				
uld be detached uld be detached ed by Physic	nt II. Other significant conditions co	ontributing to death but r	not resulting in the u	underlying cause g	given in Part I.	23e. Did tobace 1 ☐ Yes		the cause of death?
e has been si	Seigne Diso	nder	- Diser	26		24a. Was an autopsy performed	death?	topsy findings availal
rector, page 2	. Was case referred to medical examiner?		Charles Fr		26. Place of Dea	1 ☐ Yes 2 ☐ th (Check only one)	NO ILITES	2 No
this ce	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient		AIT 3 DOA		ome 5 Residence		ify)
Afte fune	. Manner of Death 1 Datural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 [Tes 2 No	28d. Describe how i		The state of the s
ral Dirac led in by Certif	4 Homicide determined	building, etc. ((Specify)			City or Town, S	tate)	
Completely filled in by the Medical Certificat	a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of r siner: On the basis of ex and manner state	xamination and/or in	th occurred at the I nvestigation, in my	time, date and place, opinion, death occur	, and due to the causi rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	b. Signature and title of certifier				6508	29d.	Date signed (Month	216
30.		completed cause of deal	th (Item 23a) (Type,	Print) X/A	MERCULL.	STAD	215	

04-00657 Nicholas Tonic B.K.S 1- State Registrar 19b per Fri, C828, 02/03/04 dnib Certificate of Department of Health and Mental Hygiene Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNKNOWN 04-027 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** A^{M} 23, 2004 JAN. 0903 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death . **Examiner** HURDER B. B. Date of Birth Month, Day. ANNE ARUNDEL 7549 TEAGUE ROAD -WOODED AREA Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 220-31-6843 12M 2□F Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show rai", or items 23e or 28a-f show 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2100 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 You ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced *naturai the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be find and Mental Figure 12 is marked of R. . Pages 1 and 2 should be ment of Health and Menta tent: If item 27 is marked ONIC ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mother usan lunic 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Important: If any injury or once. -02-04 Cattimore 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Voucinn 21. Signature of Funeral Service Licenses Greene tuneral Pike , Buttimore 23a. Part 1. Enter the dise se, or complications that caused the death. shock, or heart failed e. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final wound to head Physician Gunshot disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▶ Yes 2 □ No 24a. Was an autopsy performed? 1X Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: $_{4\,\square\,\,\text{Nursing Home}}$ 5 $\square\,\,\text{Residence}$ 6 XX ther (Specify) AT SCENE Certification: To 1 XYes 2 ☐ No this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation Subject was Shot

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 1□Yes 2□No death. Jan 23,2004 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ~ 4 Homicide Ent Red del Conty MD found To the Hospital within 24 hours ar ~ wooded aree 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E ALD aux hou del ser 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print) Abern 111 Penn Street, Baltimore, Maryland 21201 Grue 32. Registrar's Signati 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Marylar		artment of H			giene Reg. No. 2 (101.	02871
	Physic		1. Decedent's Name (First, Middle, Last)	ence The	OMAS	JR.		2. Date of De Month JANUAF	ath Dav	Year 2.004	3. Time of Death
}	/Medi Examii		4a. Facility Name (If not institution, give s HARBOR HOSP	treet and number)	ER	4b. City, Town, or BALTI	MORE	ath	4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 212-05-7770 6. Sep Usual Residence of Decedent	7. Age (In yrs. 91	last birthday) Yrs.	Months Days	If Under 24 Hr Hours Mir		th y, Year) , 1913	9. Birthpla Count Matry	
	Maryland -f show	tor	10a. State 10b. County Md. N/A	10c. Ci	ty, Town or Lo					10	d. Inside City Limits 1 Y Yes 2 □ No
	th with the 23a or 28a at Le roti	al Director	10e. Street and Number 3735	Saint Victor	St	10f. Zip Code	21225		10g. Citizen of USA	What Count	ry?
980	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or tlems 23a or 28a-f show int, the Medical Evartine must be redified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	I2. Was Decedent Ever in L Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WW		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No arto Rican, etc.)	- 14. Ra Bla Speci	ice - America ack, White, e	
21215-0036	id within 72 ho giene. er than "netui . Itse Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) Unknown U		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of w ()	orking	16b. Kind of I	Business/Indi	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ins Me	To Be (Clarence Thor			Julia		elby		
Baltimore, Mar	es 1 and of Health if item 27 or other tr		19a. Informant's Name/Relationship (Ty, Donis E. Dieh] 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	(Daughter)	5325 Place of Dispondermetery, crem	ng Address (Street as Kerger F sition (Name of matory or other place Crematory	Rd., Ell	icott Ci	ty Mc	. 21	LO43 m, State
Baltir	permit. Page Deportment of Important: If any njury or		21. Signature of Funeral Service License		ker Mc	Name and Address CUITY-Po To E. Pata er the mode of dvin	s of Facility I yniak F	uneral H	ome, P.	A. 212	Maryland
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	eations that caused the deal e cause on each line. HYPOXIA	th. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory ar	rest,		Approximate interval Between Onset and Death
5.4	/Medical Examiner	er	Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect ACUTE Cus to (or as a consect	ESPI	RATORY	FAIL	URE		3	2 DAYS
,0928	cate be executed physicien and the burial-transit	dical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	M YO CAR Due to (or as a consec	DIAL quence of):	INF	RCTI	ON_		ø	2 DAYS
P.O. Box 68	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely tilled in by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregn: 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c	ildeath 3□	Ectopic pregnancy Other (specify)			I	ate of delivery onth D	/ Day Year
rds, P	quires that in signed b uld be deta	5	Part II. Other significant conditions con	tributing to death but <i>n</i> ot res	ulting in the ur	nderlying cause give	en in Part I.		obacco use con ′es 2⊠No		cause of death?
of Vital Records,	The law requir cate has been si page 2 should	Completed						24a. Was autop perfor	sy	prior to comp death?	sy findings available pletion of cause of
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	italy 1 a		Out.		eath (Check only o	ne)		
of	Physi this c	ျို	TES 20 NO	1	ER/Outpatien		4 LI Nursing	Home 5 Resid			
Division	or Attending Phatter death. Director: After thin by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h	28b. Time of Injury	Work M 1□1	at :? ∕es 2 □ No	28d. Describe h			Route Number
Δ	To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the		4 Homicide determined 29a. Certifier 1 Certifying Phys	building, etc. (Special	(y)	occurred at the tim	e, date and plac	City or Tow	m, State)	20001 20 0101	and .
	e Ho 24 h e Fui fetely	Medical	(Check only 2 Medical Examir one)	er: On the basis of examina and manner stated.	ition and/or inv	restigation, in my op	inion, death occ	curred at the time, o	date and place,	and due to the	he cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License			29d. Date signe		31, 2004
10	+ 1		30. Name and address of person who co IGOR DOROKHINE,	npleted cause of death (Iter Department	of Med	Print) icine, Har	BOR HOSF	sital,300	South	HANOV DRE MOR	er St.,
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature				COLUMN TO THE PARTY OF THE PART	7 - p 3-11	-

				of Maryland / D)epai		th and M	lental Hy		_	02875
	_		Decedent's Name (First, Middle, Last)					2. Date of De.	ath	Vana	3. Time of Death
	Physicia /Medic		Do	rothy A. T	Cuti	ln		Feb.	1 Day	200^{Year}	91000 M
	Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or Loca			4c.	County of Death	
			1634 Bowleys Quart	ers Road		Middl		er	F	Baltimo	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birti			nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birth	plece (State or Foreign intry)
s (Director		210-20-1947	72	Yrs.					931 Ma	ryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Loca	ation					10d. Inside City Limits
	Manyl f sho	ō	MD Baltimore				Middle	e Rive	r		1 ☐ Yes 2 ☑ No
	28a-	rect	10e. Street and Number			10f. Zip Code				ten of What Cou	intry?
	3a or	Ō	1634 Bowleys Quart	ers Road		212	20		USA		
	death with the Maryland ms 23s or 28s-f show	Funeral Director	11 Marital Status 12. Was D	Decedent Ever in U.S.	13. W	as Decedent of Hispani Yes, specify Cuban, Me	ic Origin? (Spe	ecify Yes or No	- 1	4. Race - Amen	
0	or Ite			Forces? es 2 ∰No Give		_	ecity:	Hican, etc.)		Black, White	
200	rel',	d by	3 ⊈Widowed 4 □ Divorced Year	or Dates:						Specify: Whi	LLE
ה ה	be fied within 72 hours after death with the Marylan to the Hygiene. d other than "neture!", or items 23a or 28a-f show event, it a Medical Examentation in Allies at	Completed	15. Decedent's Education (Specify only highest grade complete	16a.	Decede (Give ki	nt's Usual Occupation and of work done during O NOT use retired)	most of work	ing	16b. Kir	nd of Business/Ir	ndustry
7	hen.	ld m				emaker			C	own hon	ne
V	e filed within all Hygiene. other than vent, the Me		17. Father's Name (First, Middle, Last)		101110		Mother's Name	(First, Middle,	Maiden	Sumama)	
	ntal hed of	Be	John Sobczynski					Janows		Jumame)	
	hould d Mei mark matic	은	19a. Informant's Name/Relationship (Type, Print)	19h	Mailing	Address (Street and N				Town State 7	n Code)
Z Z	trau		Edward Tutin /son			BowleysQ					
e e	f Heal f Heal item 2 other		20a. Method of Disposition	20b Place of	Disnosi	tion (Name of	· r	nate T		cation - City or T	
baltimol	00		1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	om State Holly	y, crema yHi.	tory or other place)	y 2/4,	/04	Ba]	Ltimore	e MD
	그 튼 뿐 글 .		21. Signature of Funeral-Service Licensee	0.0			-h		7	7 77	- CD
מ	Depa Impo sny is		& Tirring	and the		Name and Address of F	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	nella	rune	ralHom	eofEssex
•			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death	10t enter	the mode of dying, suc	h as cardiac d	or respiratory ar	rest,	MD ZI	Approximate
	Physician		Immediate Cause /Figal	7	all a		000	/ 4:			Interval Between Onset and Death
	/Medical		resulting in death)	to (or as a consequence of		drien (Cerc	inen.	<u></u>		
	Examiner		Pr	(mary O) Vo	In.	in Car	Cino	Tax.			28 mos
-		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence of	of):						
	cuted	Examiner	Cause (Disease or injury that initiated events c								
,00/	ite be executed ysician and he burial-transit		resulting in death) Last Due	to (or as a consequence of	of):						
-	ate b hysic the b	Ilcal	d		-						
20 2	death certificate to a standing physical for use as the b	Physician/Med	IF FEMALE:	outcome of organisms						1	
gox	ath c attend or us	lan/	in the past 12 months?	outcome of pregnancy ve birth 2 Fetal death		ctopic pregnancy			2	3d. Date of deliving Month	rery Day Year
5	the a	ysic	1 7 Voc 2 7 Min	egnant at time of death nknown	5 🗀 (Other (specify)					•
r	sician: The law requires that the de centificate has been signed by the : rector, page 2 should be detached	Ph	Part II. Other significant conditions contributing t	o death but not resulting in	the unc	teriving cause given in f	Part I.	23e. Did to	obacco us	se contribute to I	the cause of death?
cords,	sign d be	d by				, ,		101	(es 2,2	No 3□Pro	bably 4 Unknown
Ö	y requ	ete						24a. Was			oney findings available
Ū	The law ate has b page 2 st	Completed						autop	rmed?	prior to co	opsy findings available ompletion of cause of
	n: The ficate r. pa		OF the case referred to modical					1 Yes	2/2 No	1 🗆 Yes	2 No
5	Sicial	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	☐Inpatient 2☐ER/Out	tentiont	0.1		(Check only o		Other (Speci	
ō	Attending Physician: redeath. ector: After this certific. by the funeral director.	\vdash		ate of Injury 28b. T	ime of	28c. Injury at		28d. Describe h			<i>Ty)</i>
0	oding th. TAfte	tlor	1 ☑ Natural 5 ☐ Pending (Maccident investigation	fonth, Day Year) Ir	njury	Work? M 1 ☐ Yes	2 🗆 No				
DIVISION	Atter	Certification:	3 Suicide 6 Could not be	ace of Injury - At home, far uilding, etc. (Specify)	rm, stree	et, factory, office					al Route Number,
5	s afte	Cert	4 - Hounday	uliding, etc. (Specify)				City or Tox	m, State)		
	To the Hospitel or Attending Physician: within 24 hours alter death To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only 2 Medicel Exeminer: On the	the best of my knowledge,	, death	occurred at the time, da	te and place,	and due to the	cause(s)	and manner as s	stated.
	in 24 the Fi	edical	one) and n	e basis of examination and name and name stated.	wor inve						
	To t To t	Σ	29b. Signature and title of certifier). 1 /		29c. License num				signed (Month,	
	(Wellian V. II	r-sulle		D16.	801		d	- L-	-04
	0		30. Name and address of person who completed of	ause of death (Item 23a) (Туре Р	rint)	100	2 21	73	Z	
					6	tal Tomore	Res	01/1	1	f .	
200	Sta Registr		31. Date filed (Month, Day, Year) / 35	2. Registrar's Signature	A. S	all a					
	-		LED A 9 CAAL	in the state of	15000						

DHMH 17 Rev 1/2001

Donothy ANNA TUT: N 2/1/04

			Please I			adelible ink. E		•	•	
			For State	State of Ma		artment of Hea rtificate of De			2004	02876
	Will and	-	Registrar 1. Decedent's Name (First, Middle, Last,)		rimeate of Be	Jan	2. Date of Death	J. No.	3. Time of Death
	Physici	_	Mary There		r			Month January	29 2004	5:29 P ^M
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Death		4c. County of Deeth	
	ida. Galeka	Ĭ.	Greater Baltimore	Medical Co	enter	Towson			Baltimore	.
被	Funeral Director		5. Social Security Number 6. Security Number 15. Social Security Number 6. Security Number 15. Security Nu	7. Age	(In yrs. last birthday) 80 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthr 1923 Con	place (State or Foreign necticut
			Usual Residence of Decedent			<u> </u>				
	arylan show		10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	8a-f	Director	Md. Baltimor	е	Towson	101 7: 0-1-		100	Citizen of Mines Court	
	s within 72 hours atter death with the Maryland Jene. I than "natural", or tlems 23a or 28a-f ehow The Madical Examinat must be nutified at	i Dir	10e. Street and Number 7001 Charles St	•		10f. Zip Code 212	04	100	g. Citizen of What Cour	USA
	deall	Funeral	11. Marital Status	12. Was Decedent Ex Armed Forces?	ver in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban,	anic Origin? (Spe	ecify Yes or No-	14. Race - Americ Black, White,	
õ	or It		1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give			Specity:	,		White
215-0036	ural',	d by	3X Widowed 4 □ Divorced	Year or Dates:	16a Daga	dent's Usual Occupatio		16	6b. Kind of Business/In	ductor
င်	in 72	ojete	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	kind of work done duri DO NOT use retired)		ng	ob. Kind of Dusinessin	ousny
7[7	y with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+ +2	Hom	nemaker			Own Hom	е
פ	E T T	ВеС	17. Father's Name (First, Middle, Last)			18		(First, Middle, Ma		
<u> </u>		ToE	Richard Geary				Margar			
Maryland	0 4 - 6		19a. Informant's Name/Relationship (T)			ing Address (Street and				
	1 and Health Iom 27		Mary Jo Gordon/ Day Method of Disposition	augnter	20b. Place of Dispe	Drohomer			Oc. Location - City or To	
و	ages nt of 1 t: Hite		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cre	matory or other place) Service Co	. 2-3-0		Towson, M	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Figneral Service Licens		<u> </u>					
ñ	Dep Imp any) Kth			2. Name and Address of RUCK TOW 1050 YOY	k Rd. To	owson, Mo	i. 21204	
3			23a. Part1. Enter the disease or shock, or heart failure. List only o	ications that caused t						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Gr		gative St		Tyndro		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	4.0				24hours
	-8	-	Sequentially list conditions,		consequence of):	ted coi	1011			a Thous
/	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
o î	be executed Ician and burial transit		that initiated events resulting in death) Last	Due to (or as a	consequence of):					
3/60		lcal	(d					-	
X 68	death certificate e attending phys od for use as the	Physician/Medic	IF FEMALE:	12a If was autooms a						
X Q Q	attenc for us	ian	in the past 12 months?	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of delive Month	ory Day Year
o.	Q o Q	ysic	1 □ Yes 2 ☑No 9 □ Unknown	9 Unknown	ine or death 5					
7	res that signed by be deta	by Ph	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	underlying cause given i	in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
ecords,	w requires been sign should be							1 🗆 Yes	2 No 3 Prot	ably 4 Unknown
ဝ္ပ	The law requires that the tile has been signed by th bage 2 should be detache	Completed						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
r		Com						performe 1 ☐ Yes 2	d? death?	
VIta	cian: ertific actor,	Be (25. Was case referred to medical examiner?	faccitate a			6. Place of Death	(Check only one)	-	
0	Physi this c	. To	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatien 28a. Date of Injury				me 5 Resident	ce 6 Other (Specif	y)
0	ding P h. After I	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	Work?	s 2 No	Egg. Describe now	injury occurred	
Division	Attendi r death. sctor: A by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, farm, st	reet, factory, office			et and Number or Rura	il Route Number,
	safte safte al Dire	Certification:	4 Homicide	building, etc.	(Зреспу)			City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e and manner state	examination and/or in	th occurred at the time, evestigation, in my opini	date and place, ion, death occurr	and due to the cau ed at the time, date	se(s) and manner as s e and place, and due to	tated. the cause(s)
	othe othe omple	Mec	29b. Signature and title of certifier	21.7 Hamilet 3(4)		29c. License ni	umber	290	I. Date signed (Month,	Day, Year)
)	1		mark S. A.	on of &	7	200	580	82	1/30/00	4
	(0		30. Name and address of person who co	ompleted cause of de		Print)	1	() 2	12011	1
			6+01	N-CHa.		t lowso.	n, 14	0 21	204	
	Sta Registi		31. Date filed (Month, Day, Yelar)	32. Registrar	Sognature	4 Gradi				
100	5		1, 120	0 0 2001 A	10 3 1 1 2 - 15 1 1 2 C	1				

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For Amend Item 27 p	State of Maryland / Der Dr.,G828,02/03/04	epartment of Health and Certificate of Death	Mental Hygiene	; .2006 02877
		Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
Physic		Vera Thomas	50n		Jan 2	
/Med Exami		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Deat	h 40	County of Death
		FUTURE CARE	LRVING ION	MALTIMORE		NIA
Funera Director	1	5. Social Security Number 6. Sex 1 Usual Residence of Decedent		nday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
and wc		10a. State 10b. County	, 10c. City, Town	or Location		10d. Inside City Limits
Mary -f sho	ট্	MYD N//	9 MAL	TIMORE		1 1 Yes 2 □ No
r 28a	Director	10e. Street and Number	11 0-	10f. Zip Code	10g. C	tizen of What Country?
th with		22 9. ATM	01 971	71779		4.7.A
72 hours after death with the Maryland natural', or Itams 23e or 28e-f show Jical Examiner must be notified at	Funerai	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
S afte		1 Never Married 2 Married	1 ☐ Yes 2 ØNo If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: PACK
72 hours "natural",	d by	3 ☐ Widowed 4 Divorced 15. Decedent's Educ	Year or Dates:	Decedent's Usual Occupation	16b k	(ind of Business/Industry
thin 72 hours af e. "natural", or	Completed	(Specify only highest grade	completed)	(Give kind of work done during most of wo life. DO NOT use retired)		and or Educational Made and
ad within rgiene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	TEACHER	A	GH SCHOOL
a filed Il Hygi other	(a)	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maide	Surname)
should ba nd Mantal marked o	To B	BROCK MA	RS	19/1/2	RJA HA	VE9
S S E E	-	19a. Informant's Name/Relationship (Typ	pe, Print) 19b.	Mailing Address (Street and Number or R	ural Route Number, City	or Town, State, Zip Code)
alth a	5	MATTIE M. TREE	MAN 5	729 WOITE 19VE	R-LANE (Dumpin 11 17,2104
		20a. Met od of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	comoton	ispos ion (Name of v, crematory or other lace)	Date 20c. L	ocation - City or Town, State
nit. Page artment o ortant: If injury or		'4 □Donation 9 □Other (Specify)	a / PROW	V EMPLE 1-1	UT TAN	MENNE ENINO
parmit. Pag Department Important: sny injury		21. Signature of Paneral Service Liceose		22. Name and Address of Facility	2-70 FREDIH	1LTON 1095 21724
Dep men		May 1/1 /n	N	GARN P. MARCH F	UN/59RA / 40M	TE PIA DATIMIVI
		23a. Pant. Enley he disease, or complied shock or beart failure. List only on	cations that caused the death. Do n e cause on each line.	ot enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
Physiciar		Immediate Cause (Final disease or condition	Increasing tai	-dive dyskinesia		Criser and Death
/Medica		resulting in death)	Due to (or as a con equence of	rf):		
Examine		Satuentially list conditions, b	Schizophre			
sit sit	iner	Sa uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	():		
ecute and I-tran	Examin	that initiated events resulting in death) Last	Due to (or as a consequence of	remia		
of 00, cate be axecuted obysician and the burial-transit			Ducohasia	5/0 DEF		
icate phys	Physician/Medical		- P95/10 -	2//9 F. 0. B	1	
DUX OC death certifica attending pt for use as tl	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	120		23d. Date of delivery
eath cert attendin	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
that the de add by the a	ysi	1 ☐ Yes 2 MNo 9 ☐ Unknown	9□ Unknown	- El 202 2		
I NECOLUS, F.O. DUX 00/00, The law requires that the death certificate be axecuted as been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Pt	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
COLOS, P. C. W. requiras that s been signad t should be dete	ρ	chronic a	memia		1 ☐ Yes 2	Probably 4 ☐Unknown
w red a	Completed	constiga	tion		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
nec The law te has a	E	0 = (1 = 1 =	(performed?	death?
VICAL P ilcian: Th certificate rector, pag	a	25. Was case referred to medical		26. Place of De	ath (Check only one)	
OI VILEI Physician: rthis certifica	To B	examiner? 1 Yes 2 No	lospital: 1 Inpatient 2 ER/Out	patient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
ding Phys h. After this funeral dia		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. T	ime of 28c. Injury at hijury Work?	28d. Describe how inju	ry occurred
UIVISION OT VITAI HECOTAS, I or Attending Physician: The law requiras I after death. Director: After this certificate has been signs in by the funeral director, page 2 should be	Certification:	2 Accident investigation		M 1 ☐ Yes 2 ☐ No		
r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street a City or Town, Star	nd Number or Rural Route Number, 'e)
To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funaral director, page	Cer					
Hosp 4 hou Funal ely fil	ledical	(Check only 2 Medical Examil	ner: On the basis of examination and	, death occurred at the time, date and plac Dor investigation, in my opinion, death occ	e, and due to the cause(: urred at the time, date ar	i) and manner as stated. Id place, and due to the cause(s)
To the Hospital within 24 hours of the Funaral completely filled	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29d. D.	ate signed (Month, Day, Year)
5 will 50		250. Signature and title of certifier	ing D			01/22/04
		1 3 600	my	D60141		0.10011
		30. Name and address of person who co	mpleted cause of death (Item 23a) (M G 821 N	Type, Print) Eutaw Street	Suite Z	of Baltimore m
	toto	31. Date liled (Month, Say, Year)	32. Registar's Signature			2/20/
Regis	tate trar	- D1/33/10000	2004 Daggera A	(Scarte		

			For State Registrar	State of Maryland /	-	rtment of F		nd Mental	Hygien	2111	14 ()2878
	· ·		1. Decedent's Name (First, Middle, Last)					2. Date of		ay Yo	ar 3.	Time of Death
	Physicia /Medic	·al		rd O. Ulrich				JA		,		8:20 p M
)	Examin		4a. Facility Name (If not institution, give str			4b. City, Town, o			4	c. County of I		
			Renaissance Garde			If Under 1 Year	Catons		4 Diah		timor	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last I	Yrs.	Months Days	Hours	Min. (Monti	h, Day, Yea			(State or Foreign
	Director		212-09-7103 Usual Residence of Decedent	87			1	JUL	26, 1	916 _	Maryl	and
	and and		10a. State 10b. County	10c. City, To	wn or Lo	cation					10d.	Inside City Limits
	f sho	ō	Maryland Baltimo	ire		Catonsv	i11e					1∐Yes 2∭∏No
	158 288 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Directo	10e. Street and Number	10		10f. Zip Code	1110		10g. C	itizen of Wha	at Country?	
	3a or		719 Maiden Choic	e Lane HR302		2122	8			USA		
	death ms 2	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. Amed Forces?	13. \	Was Decedent of h	Hispanic Origi	n? (Specify Yes of	or No-	14. Race -	American I	ndian,
9	after or ite	큔	1 Never Married Married	1X Yes 2 No	1	1 ☐ Yes 2Ã No		r donto riibani, bio	.,	Specify:	Whit	Α
93	72 hours after death with the Maryland natural', or items 23a or 28a-f show disal Examiliae musi be invilled at	d by	3 Widowed 4 Divorced	Year or Dates: WW 1 1								
21215-0036	72 h	Completed	15. Decedent's Educa (Specify only highest grade		(Give	ient's Usual Occup kind of work done DO NOT use retire	during most of	of working	16b.	Kind of Busir	ness/Indust	ry
121	vithin ne. han '	臣	Elementary/Secondary (0·12)	College (1-4or 5+)		Preside			Λ.	sphalt	Todu	ctra
	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or items 23a or 28a-f show deent, the Medical Examiner must be mylified at		17. Father's Name (First, Middle, Last)	1	VICC	TTCSTGC		s Name (First, M.		-	THUU	БСГУ
anc	ould be f Mental I warkad of atic eve	Be.	Eugene Ulrich				Har	riett Bu	rke			
Ē	should be filed withir ind Mental Hygiene. s markad other than umatic event, the M	ဥ	19a. Informant's Name/Relationship (Typ	e. Print) 1	9b. Mailir	ng Address (Street				or Town, Sta	ate, Zip Coo	de)
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Catherine B. Ulric	il il								MD 21228
	ges 1 ar t of Hea If item or other		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of natory or other pla		Date	20c.	Location - Cit	y or Town,	State
10			1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	•	ematory,		1/31/04	В	altimo	re, M	D
Baltimore,	그 든 문 글 .	1	21. Signature of Funeral Service Liquid	Enroll mill	22	Name and Addre	ess of Facility	tw of Ma	rylan	d Inc		
ä	Depa Impo any is		Dawn	icDonald		99 Frede						
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. D	o not ent	er the mode of dyi	ng, such as c	ardiac or respirat	ory arrest,	-,	Ap Int	proximate erval Between
	Pnysician		Immediate Cause (Final disease or condition		5+11	ie h.	eart	fail	we	_	On	set and Death
	/Medical		resulting in death)	Due to (or as a considered	ce of):		•	1				
И	Examiner		Sequentially list conditions b.								_	
	₽ ∺	<u>ne</u>	Sequentially list conditions, if any, leading to immediate causa. Entire Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):							
	ecute and trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	e of):							
8760,	tate be executed obysicien and the burial-transit			250 to (or 40 2 00 modeo								
	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	by Physician/Medical	d.									
9 X	aath certifica attending ph for use as t	/Me	IF FEMALE: 23	c. If yes, outcome of pregnancy						23d. Date of	of delivery	
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		<pre>]Ectopic pregnanc</pre> <pre>] Other (specify) _</pre>	y			Month	Day	y Year
P.O.	that the death cer ed by the attendin detached for use	lsk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
	res that igned b	Y	Part II. Dther significant conditions conf	ributing to death but not resultin	g in the u	nderlying cause gr	ven in Part I.	23e.	Did tobacco	use contribu	ute to the c	ause of death?
Records,	n sig old blu							_	1 🗌 Yes	2 □ No 3	Probably	/ 4 ⊡Unknown
00	sw requires been si	olet						24a.	Was an autopsy	24b. We	re autopsy	findings available stion of cause of
Re	The law ate has page 2	Completed				·		101	performed	dea	th? Yes 2	
Vital		a a	25. Was case referred to medical				26. Place	of Death (Check				
↓	Physician: this certific ral director,	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatier	t 3∐ DOA		sing Home 5 🗆	Residence	6 Other	(Specify)	
n of		ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time o Injury	Wo			cribe how in	ury occurred		
<u>Ö</u>	Attending r death. ector: After by the fune	catio	2 Accident investigation		_]Yes 2□N	_				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, sti	reet, factory, office		City o	or Town, Sta	and Number te)	or Hurai Ho	oute Number,
	lospital of hours at uneral D	ဦ	SOLO SINGLE STORY	ician: To the best of my knowle	dae deet	h convered at the	ima data and	I place, and due to	o the cause	(e) and mann	ar as state	d
	T 4 IT M	edical	29a. Certifier Certifying Phys (Check only one) Check only 2 Medical Examin	er: On the basis of examination and manner stated.	and/or in	vestigation, in my	opinion, death	h occurred at the	time, date a	nd place, and	d due to the	e cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of cedifier	A \		29c. Liden	se number		29d. [ate signed (Month, Day	, Year)
	⊢ \$ ⊢ ŏ		10-B	A. K	W	1 1) 24	242		4311	04	
-	. 6	,	30. Name and address of gerson who con	mpleted cause of death (Item 23	a) (Type,	Print)				6 1	- 11	. 1
	1		Bruce Bun	unter my	·-	tog ha	der d	nonce la	u C	www	wh	m+2,228
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	all of							
	Reaist	rar	EER 0 3 2004 *	The state of the s								

				1 State	State of Marylan	•	ent of Health and I	La Carte	- 21111	. 90270
				Registrar 1. Decedent's Name (First, Middle, Last	}	Certifica	ale of Dealif	Reg	. No. & O O '	3. Time of Death
		Physici		(enable			Month Jan Lary	21 - 2001	1 0730 AM
	7	/Medic Examin		4a. Facility Name (If not institution, give		4b. Cit	ty, Town, or Location of Deatl		4c. County of Dear	
				Gilchrest +	tospice		wnson		Baltin	ore
	de la	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	Month	der 1 Year If Under 24 Hrs. is Days Hours Min.	(Month, Dev. Y	eer) 9. Birt	hplace (Stete or Foreign
	10 S	Director		213-34-9362 Usuel Residence of Decedent	W 200F 66	Yrs.		9-21-3	57	N.C.
		ehow		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
		with the Marylar B or 28a-f ehow	tor	md BAK	70. R	andal	Istown			1 □Yes 2 2H0
		or 28,	lrec	10e. Street and Number		10f. 2	Zip Code	10g	. Citizen of What Co	ountry?
		ath w	Funeral Director	5107 old cort			2/133		4.54	1
		ltema rer mi	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 13. Was Dec	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puert	o Rican, etc.)	14. Race - Ame Black, Whit	
	336	ours after death w rel', or Itema 23s Ever incer must	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 10 No Specify:		Specity:	lack
	200		Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. Decedent's U:	sual Occupation work done during most of wor		b. Kind of Business	Industry
	21	ithin 7.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)		Daine to	-3
	121	led w tygier her th	Co	13+h 17. Father's Name (First, Middle, Last)		NU	18 Mother's Nam	ne (First, Middle, Ma	Private	
	and	ntal H	Be c	Wesley Chaxi	5 60		Masy			
	Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene. Item 27 ie marked other than "natuu other treumatic event, Ind Medical	2	19a. Informant's ame/Relationship (7)		19b. Mailing Addre	ess (Street and Number or Ru			Zip Code)
	N S	and 2 sealth arm 27 le		Geraldine W	eks -	3937 H	lart Lake st	woods	mise VJ	۸.
	Je,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 li any injury or other tre		20a. Method of Disposition	20b. F	Place of Disposition (A	Name of or other place)	Date 20	c. Location - City or	
	Ë	Page nent c ant: If ury or		1 Burial 2 Cremation 3 F 1 Other (Specify)	Removal from State	ing Parl			balto. N	id .
	alt	permit. Departr Imports any inju		21. Signature of Funeral Service Licens	90	22. Name	and Address of Facility EYChavis Eastern Av	SC F. H. O.	ال امد ال	21231
		205 2 3		Wholey (ravp	20017	Elastern Av	4 12°	iltomd.	
				23a. Part1. Enter the disease, or comp shock, or heart failure. List only o					•	Approximate Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Chronic		ctive Lung	disease		years
		Examiner	:		Due to (or as a conseq	juence or):	·			V
			Jer	Saguantially list conditions if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uenca ot):				
		ie be executed ysicien and e burial-transit	Examiner	Cause (Disease or injury that initiated events	c					
ul ,	760,	e exe		resulting in death) Last	Due to (or as a conseq	uence of):				
3)	687	¥ × 9	dical		d					
3	9 X	Attending Physician: The law requires that the death certificate be excideath. •ctor: After this certificate has been signed by the attending physicien by the funeral director, page 2 should be detached for use as the burian	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of del	iverv
2	.O. Box	death a atter	clar	in the past 12 months? 1 □ Yes 2 🛣 No	1☐Live birth 2☐Feta 4☐Pregnant at time of d				Month	Day Year
0.		that the death ed by the atte detached for	hys	9 Unknown	9□ Unknown			_	_	101
0)	s, D	signed be del	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	g cause given in Part I.			the cause of death?
mable	ord	w require been si should I	ted	Dementia	- 001 1	-		1 ☐ Yes	2 ∐ No 3 ∐ Pr	obably 4 1 Unknown
E	ec	law ras be	npie	gastro intest	inal Bleedi	ng		24a. Was an autopsy	prior to	topsy findings available completion of cause of
2	E H	cate t		J		0		performe 1 Yes 2		2□ No
0	Vita	ding Physician: The law n. After this certificate has t funeral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	1500	Other	ath (Check only one)		11.00
0930	ō	Phys rr this sral di	To To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 28b. Time of	28c. Injury at Work?	lome 5 Residence 28d. Describe how		City) ITOSPICE
0	ion	nding F ith. r: After e funer	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yeer)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
HO	Division of Vital Records,	or Attendi efter death. Director: A in by the fu	tifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact	ory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
-31-04	Ö	ital or A	Cer							
T	ax.	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical Certification:		rsician: To the best of my knoiner: On the basis of examina and manner stated.					
	•	To the within 2 To the comple	Me	29b. Signature and title of certifier	15		29c. License number		. Date signed (Monta	
	• ,	1		I all hish	y Killy 1.	no	025005	J.	MUANY :	31,2004
	V			30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type, Print)	025205 lest. Bolt	L M 1 7	1206	
	٤			31. Date filed (Month, Day, Year)	- gmc 6701 32 Registrar's Signa		us st. Wat	0. Med 2	1007	
	36	Sta Registr		PEN A C COA	. C	G (2)				

DHMH 17 Rev 1/2001

ORIGINAL

				State of Ma	arylan	•	rtment of <i>tificate of</i>		nd Me		- 00	101	00000
	Dhusisian		Decedent's Name (First, Middle, Las	st)		001	inoate of	Dodin	2	. Date of Dea Month	ith Day	Year	3. Time of Death
	Physiciar /Medica		Joseph	Vaz	20	na				01-	30-2	2004	6:15 PM
)	Examine	4	Fecility Name (If not institution, give					4b. City, Tow	m, or Loca	tion of Death	4c. County		
<u>.</u>			Multi Medica				If Under 1 Year		0003				nove
	Funeral Director	2	F(102 2 12)	ex 7. Age	a (In yrs.	last birthday) Yrs.	Months Days		Min.	Date of Birtl (Month, Day			place (State or Foreign ntry) ryland
	D .		suel Residence of Decedent la. State 10b. County		10c Cit	y, Town or Loc	ation					1	0d. Inside City Limits
	aryla sho		MD Baltimo	70		uthervi							1 ☐ Yes 2 ☑ No
	vith the Ma	3 1	le. Street end Number	16		u dilet v.	10f. Zip Code				10g. Citizen of	What Cour	
	F 5	5 "					210	10.2			United		
	laath	2 11	5 Lynn Court Marital Stetus	12. Wes Decedent E Armed Forces?	Ever in U,	S. 13. W	as Decedent of Yes, specify Cul		in? (Speci	fy Yes or No-		e - Americ	an Indian,
020	ors a	D L	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 N If Yes, Give Year or Detes:	ю Wu	I TTI	Yes, specify Cul ☐ Yes 21∑ No		Puerto Ric	can, etc.)	Specif	ck, White, y:	etc. White
21215-0020	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation		16a. Decede	ent's Usual Occu	pation during most o	of working	,	16b. Kind of B	usiness/In	dustry
2	within ena.		Elementary/Secondary (0-12)	College (1-4or 5	+)		ind of work done O NOT use retin	9d)			Bethle		
	ad w	3	5 11 1 11 15 15 15 15 15 15 15 15 15 15	2+			Clerk	40 84-46-4	la Nama //	First Middle		hipya	ard
E C	should be filed within and Mantal Hygiena. a marked other than " umatic event, the Mar	ŏ	'. Father's Name (First, Middle, Last)								Maiden Suman	10)	
Maryland	should be fand Mantal I	2	Philip Vazzar			10h Mailin	Address (Stree	Louis			luetta r Citror Town	Stato 7in	Codel
	d 2 sho th and 7 is me traum	1	9a. Informant's Name/Relationship ((2006)
	1 and Haalth am 27 other tr	20	Jocelyn Kavanac	h/daughter	20b. P	lace of Dispos	n Court			le, MD Date	21193 20c. Location -		own, State
<u>ē</u>	agas nt of nt of nt of	-	1) Burial 2 ☐ Cremation 3 ☐		1		atory or other pla dral Cer		Π ₂ /ι	03/200	. Rol	+imar	o MD
Baltimore,	it. Partma	2	4 ☐ Donation 5 ☐ Other (Specify 1. Signature of Funeral Service Licen		INEU		Name and Addr			-			e, MD łome, Inc.
Ba	parmit. Pagas 1 an Dapartmant of Haal Important: if itam 2 any Injury or other once.	317	Sould De	S.Coster			1050 Yo	rk Road	f Tol	wson, l	Marylan		204
		2	 Part 1. Enter the disease, or com shock, or heart failure. List only 	plications that caused one cause on each lir	the death ne.	h. Do not ente	r the mode of dy	ing, such as ca	ardiac or r	espiratory ar	rest,	1	Approximate Interval Between Onset and Death
) I	Physician	Ι.	amediate Course (Final		- I	1 0						1	Cristiand Death
	/Medical Examiner	d	nmediate Ceuse (Final sease or condition esulting in death)	ө	()	HF							
握	۽ السو		, , , , , , , , , , , , , , , , , , , ,	Λ	Due to (o	r es e consequ	ence of):					i	
1	nsit		•	b. A S	> (1 12						1	
3	axecutering and and and and and and and and and and	Sid	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury		Due to (o	ras a cons e qu	ience of).					1	
68760,	icata be axecute physician and s tha burial-tr-nsit	C th	at initiated events	c	Due to (o	r as a consequ	ence of):						
89 ×	artificat ling phy a as th		sulting in death) Last	ď	200 (0)		0,100 0.7.					, , ,	
Box	at the death certiful by the attending leteched for use a						-,					-	- (c) c
o	the schad	Pa	art II. Other significant conditions of	ontributing to death bu	ut not resu	ulting in the un	derlying cause g	iven in Part I.				-	the cause of death?
P.0	that the ed by data		DNEUMON	ion	Th.	dono	o cuto	panie	a.	101	es 2 No	3 ⊌ Pro	bably 4 Unknown
of Vital Records,	The law requires that the death cartificate be executed at a bean signed by the attending physician and page 2 should be deteched for use as the burial-transit commissed by Dhysician Madical Example.		Dementio	,				· · · · · · · · · · · · · · · · · · ·	_ ′	24a. Was a perfor	an autopsy med?	av	ere autopsy findings ailable prior to mpletion of cause death?
Re	a law									101	es 2Lano		Yes 2 No
<u>r</u>	n: The ficate or. pa		5. Was case referred to medical					26 Place	of Death /	Check only o		1	J 165 2 (2) 110
₹	Physician: Tha law this cartificata has the director, paga 2 see T. P. P. Complete.	ה ביו ס	examiner?	Hospital: 1 Inpatie	nt 2 🗆	ER/Outpatient	3□ DOA O	han /	_		ence 6 □Oth	er (Specif	v)
o	Phy arthis araic		. Menner of Death	28a. Date of Injur	y	28b. Time of	28c. Inju				ow injury occur		,,
o	Attending or death. Afta by the fund by the fund iffice the		1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey	(Year)	Injury		Yes 2 □ N	lo				
Division	After dag ector by th	<u> </u>	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Inju	ury - At ho	ome, farm, stre	et, factory, office		28	f. Location (S City or Tow		er or Rura	al Route Number,
Ö	itsi or Attending P its aftar death. Si Director: Aftar it lad in by tha funars	5	4 Tromode	bollding, etc	. (Opecin)	<i>"</i>				17.70	,,		
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this complately filled in by the funeral di	2	9a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysiclan: To the best on niner: On the basis of and manner ste	examina	wledge, death tion and/or invo	occurred et the t estigation, in my	ime, date end opinion, death	place, and occurred	d due to the d at the time, d	ause(s) and ma late and place,	anner as s and due to	tated. the cause(s)
	Withir To the comp		b. Signature end title of certifier	<u> </u>			29c. Licer	se number		2	29d. Date signe	d (Month,	Day, Year)
	111		> Mh	ede	N	D	D	6053	39		1-3	1-7	0 4
	12/	30). Name and address of person who	completed cause of de	eath (Item	1 23a) (Type, F	rint)					<u> </u>	
	0 1	1	Vijay R. teegde, M			tow St	-, Swite	308,	Ba	ltimo	IVR, W	0 3	11201
	State Registra	1	Date filed (Month, Day, Vear)	9 2004	3 Signa	ture	Louis	0					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month February Mary Agnes West 4:15 P M 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day, Yeer) NOV. 15, 1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 XF Director 215-24-1081 76 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3013 Moreland Avenue 21234 U.S.A. "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H is marked of Pages 1 and 2 should be ment of Health and Menta sant: If item 27 is marked William John Long Mary Jeannette Duvall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. H. Robert West (husband) 3013 Moreland Avenue, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 2/4/2004 Bayview Crematory Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Bartimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2A5T210 unta /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medicai attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day signed by the at d be detached to 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) P 1 Yes 2 No this Director: After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident illed in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 53303 me and address of person who company

Weller Wy Golf Registrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Ppm) St Baltimore MD rarle; 31: Date filed (Month, Day, Y 3 2004 State Registrar

2-1-04

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2:50P M 30, 2004 Marian Wheeler Wingard Jan. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cockeysville
If Under 1 Year | If Under 24 Hrs. Broadmead **Baltimore** Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Days Hours 1 ☐ M 2 🗓 F 92 215-22-6967 9, 1911 Maryland Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or itame 23a or 28a-f show ury or other traumatic event, the Madical Examines must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13801 York Road 21030 USA by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: f Yes, Give White 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be 0 Joshua Wheeler Betty Bixler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Windemere Parkway Phoenix, MD 21131 Millard Cursey, Jr. 20b. Place of Disposition (Name of commetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot Feb. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. 21. Signature of Fureiral Service Eicensee 10 W.Padonia Road Timonium, MD 21093 Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a insequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) 68760, Physician/Medical as the the attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Records, P.O. 9 Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No 1 Yes 2 🗆 No Division of Vital completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Thursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? : After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of death (Item 2-a) (Type, Print) 801 32. Registrar's Signature 31. Date filed (Month, Day, Year) State A-CAPE A Registrar FEB 0 3 2004

ORIGINAL

			-	State of Maryla	nd / Dep	artment of	of Health and	d Mental Hy	giene o o o	01 00000
			1 - For State Registrar	,			of Death		Reg. No.	14 02663
	Physici	an	1. Decedent's Name (First, Middle, La	ist)		WA	LBURN	2. Date of De Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, given The Johns Hopki	11.	(0	more C	eath	4c. County of N/	Death
September 1	Funeral Director		5. Social Security Number 6.5		s. last birthday Yrs.	If Under 1 Y Months D		frs. (8. Date of Bi (Month, Da Oct. 9). Birthplace (State or Foreign Country) Pennsylvania
	Maryland I-f show	tor	10a. State 10b. County	Arundel	City, Town or L Linthi	ocation	ghts			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	i Director	10e. Street and Number 419 Madingley	Road		10f. Zip Co	^{de} 21090		10g. Citizen of What	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23e or 28e-f ehow any figury or other traumatic avent, I'm Medical Exacilinar chial be notified at angle.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	Was Deceden If Yes, specify 1 ☐ Yes 2 [X]	of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or No erto Rican, etc.)	o- 14. Race - Black, Specify:	American Indian, White, etc. White
Maryland 21215-0036	within 72 hou ane. then *naturs a Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)		(Give		ccupation tone during most of v etired)	working	16b. Kind of Busin	ness/Industry Office
land 2	should be filed and Mental Hygis marked other umatic avent, II	To Be Co	12th 17. Father's Name (First, Middle, Lass Russell	1 E. Womer			18. Mother's N	Name (First, Middle E. Willi	, Maiden Sumame)	
	1 and 2 sho Health and h em 27 is ma ther trauma		19a. Informant's Name/Relationship George Walburn 20a. Method of Disposition	/ Husband	419 1		ey Road		er, City or Town, Sta m Heights 20c. Location - Cit	s, MD 21090
Baltimore,	artment of bortent: If Its Injury or of B.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	Removal from State	cemetery, cre eadowri	matory or othe dge Men	n. Park 2/2	2/2004	Elkridg	e, Maryland
Ba	permit. Departr Importe any Inje		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that dayled the de		FOOT KT	cure urdi	way Bar	timore, M	ral Home, P.A. aryland 21225 Approximate Interval Between
68760,	Physician /Medical Examiner but sicien and physicien and physicien and physicien and sicien and phys	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Leukem Due to (or as a conse c. Due to (or as a conse d	lia equence of):	<u>.</u>				one year
P.O. Box 6	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregr □ Other (speci			23d. Date of Month	
rds, P.	w requires that I been signed by should be deta	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	underlying caus	e given in Part I.	23e. Did 1		ute to the cause of death?
Vital Records,		Completed							ormed? dea	re autopsy findings available ir to completion of cause of th? Yes 2 No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	Death (Check only		
Division of \	Attending Physician: ir death. ector: After this certific by the funeral director,	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work? 1 Yes 2 No		dence 6 Other ((Specify)
Divisi	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not to determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, of	fice	28f. Location (City or To	Street and Number own, State)	or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my ki miner: On the basis of examinand manner stated.	nowledge, dea nation and/or in	th occurred at the nvestigation, in	he time, date and pla my opinion, death oc	ace, and due to the courred at the time,	cause(s) and manne date and place, and	er as stated. If due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				cense number		29d. Date signed (A	•
			30. Name and diress of person with	mpleted cause of death (Ite	em 23a) (Type	Print)	60203		January	28, 2004 yland 21231
	Ú		Rosalyn Juergens	1650 Orleans	Street	t Joh	ns Hopkin	s Balti	more, Max	yland 21231
15.	Sta Registi	36	31. Date filed (Month, Day, Year) - FFR 0 3 2004	32. Registrar's Sign	la	A. P. C. C. C. C. C. C. C. C. C. C. C. C. C.	,			

DHMH 17 Rev 1/2001

ORIGINAL

	•	For State Registrar	State of Maryland	Departi Certi	tment of H ficate of L	ealth and Death		g. No.	4 0286
Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) GARY WILLIAMS					2. Date of Death Month JANUARY	Day Yea 23, 2004	3. Time of Death 1:05P.
Examine	er	4a. Facility Name (If not institution, give s. 1001 KATHLAND AVE	treet and number)	4	BALTIMO		h	4c. County of De	ath
Funeral Director			M 2□F 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rear) (irthplece (State or Fore Country) RYLAND
ahow ed at		Usual Residence of Decedent 10a. State 10b. County MD • N/A		own or Local					10d. Inside City Lin
a or 28a-1 Le notiff	Director	100. Street and Number 4001 KATHLAND AVE			10f. Zip Code 2120	7	10	g. Citizen of What (Country?
or Items 23	Funerai	11. Marital Status 1 1 □ Never Married 2 □ Married	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	If Y	es, specify Cubai	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, Wh	
natural', o dical Exer	eted by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade		6a. Deceder	Yes 2 No nt's Usual Occupa nd of work done of NOT use retired,	Specify: tion uring most of wa	rking	Specify: B:	
Hygiene. other than ent, the Mes	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired,			RETA:	IL
i and Mental H is marked oth raumatic aven	To Be	17. Father's Name (First, Middle, Last) SAMUEL WONSON				ANN MA	me (First, Middle, MAE WILLIAN	IS	7.0.1
t of Health If Item 27 or other t		19a. Informant's Name/Relationship (Type DORRAINE REID (SIS 20a. Method of Disposition 1 월 Burial 2 □ Cremention 3 □ Re 4 □ Donation / 5 □ Øther (Specify)	STER-IN-LAW) 20b. Place come come	6450 e of Dispositi		RD. APT	Date 2	MORE, MAI	RYLAND 212
Departmen Important: any injury once.			JONATHAN D. HI						E, P.A. (LAND 2121
ysician Medical aminer sthe prival-transit	dicai Examiner	Immediate Cause (Final disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent Due to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or	INS ca of):					
attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3□E	ctopic pregnancy other (specify)			23d. Date of d Month	elivery Day Year
gue pe c	by	Part II. Other significant conditions con	tributing to death but not resultin	ng in the und	erlying cause give	n in Part I.	23e. Did toba	5	to the cause of death Probably 4 DUnkn
cate has been s , page 2 should	Completed							ed? prior to death' □ No 1 1 1 Yo	
this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No No 27. Manner of Death		/Outpatient	00 - 1	4 🗌 Nursing I	ath (Check only one Home 5 Resider 28d. Describe how	nce 6X1Other (Sp	ecitySCENE
leath. Ior: After the fune	Certification;	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	(Month, Day Year) 1 236 y FWND 28e. Place of Injury - At home building, etc. (Specify)	Injury Full 250 P	t, factory, office	res 2 No	SUBSECT	wAs ASPh	YNATED Rural Route Number, KATYLAND
4 hours Funeral	ledical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exeminates	ician: To the best of my knowle er: On the basis of examination and manner stated.	dge, death o	ccurred at the tim	e, date and plac inion, death occ	e, and due to the car urred at the time, da	use(s) and manner	as stated. ue to the cause(s)
within 2 To the	Me	29b. Signature and title O certifier	1 Pm		29c. License	number		d. Date signed (Mo	
11		/ /	mpleted daruse of death (Item 23				J		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amended #29dpermd, fchd/tsd1/204 Millicate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death :30 PM Month Yeer **Physician** 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City, Town or Location of Death Examiner CliRe If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day 9. Birthplace (State or Foreign Country) **Funeral** 28-643 10M 20F Months Days Hours Yrs. Director TOLES Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and to Health and Mental Hygiene. ant: If item 27 is marked other then *natural', or items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other then "natural", or items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at 1 Pres 2 □ No Director 10e. Street and Number 10f. Zip Cotie 10g. Citizen of What Country? 703 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No and 21215-0036 Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (Q-12) DRIVE PORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٩ 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) CLAUGHTER! Maunit Md. VAGERSTOWN MU 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot. Ballinie 1 Burial 2 Teremation 3 Removal from State -3 -09 nithsburg Chen 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility GARE 21. Signature of Funeral Service License ROLLING FUNERM HORE le m 2170 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a astro inter **Physician** disease or condition resulting in death) /Medical Due to (of as a consequence of) Examiner vance ROUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ s been signe should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 X No 2 X10 this certificate To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ို 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ∠ Residence 6 ☐ Other (Specify) After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation in my opinion, death occurred. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. JANUARY 2, 2004 29b. Signature and title of certifier 29c. License number 66

Registrar

4

State

Drine, Frederick

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

Hudhud

JAN 20

31. Date filed (Month, Day, Year)

46R

32. Registrar's Signature

			1 - For State Registrar	State of Marylan		rtment of He			ne 2004	02886
	Physici		1. Decedent's Name (First, Middle, Last) Robert	Mathew		Allen		2. Date of Death Month	Dey Year 4 2004	3. Time of Death 7:40A M
)	/Medic Examin Funeral Director		5. Social Security Number 6. Sex	norial Ho:	sp.	4b. City, Town, or Lo		B. Date of Birth	4c. County of Death	1 ,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itema 23e or 28e-f show eny injury or other traumatic event. It's Macalical Exertilier maral be notified at ODG.	To Be Completed by Funeral Director	Usuet Residence of Decedent 10a. State 10b. County 10e. Street and Number 13C2 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type) 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Idensei	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes , Give Year or Dates: ation completed) College (1-4or 5+) De, Print) Completed 20b. Permoval from State	16a. Deced (Give III) 19b. Mailing 1307 1ace of Disposemetery, crem 122.	In the second of	Specify: on ing most of working most of working. 3. Mother's Name of Number or Rura of Facility Grant	acify Yes or No-Rican, etc.) Ing If (First, Middle, Mail Acid) Al Route Number, Control Oate 2007	ity or Town, State, Zi MD. J. Location - City or T CEN (1)	ican Indian, o, etc. ACK Industry Authorize In Code) 1702 Town, State NICK ACK Town, State NICK ACK Town State
	cate be executed // Medical // Medical Examiner	al Examiner	23a. Part1. Enter-the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate outset. Each of John of Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	uence of):	vw, Scc r the mode of dying, s		or respiratory arrest,	1112 21	Approximate Interval Between Onset and Death M. WAT
. Box 6	The law requires that the death certificate tie has been signed by the attending phys bage 2 should be detached for use as the	ed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions cont	ic. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown ributing to death but not resu	death 3∐l eath 5∐	Ectopic pregnancy Other (specify) derlying cause given in	n Part I.		23d. Date of delive Month so use contribute to the contribute to t	Day Year
		e Completed	25. Was case referred to medical					24a. Was an autopsy performed	? prior to co	opsy findings available impletion of cause of
DIVISION OF VII	ng Phy fter this	ertification: To Be	examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpatient 28b. Time of Injury	3□ DOA Other: 28c. Injury at Work?	4 ☐ Nursing Hon	(Check only one) ne 5 Residence 8d. Describe how in	6 ☐Other (Special	(5y)
22	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify)	,.		City or Town, Si		
	the Hos thin 24 ho the Fun mpletely	Medicai	(Check only one) 2 Medicel Exemine 29b. Signature and title of certifier	cian: To the best of my knower: On the basis of examinational and manner stated.	viedge, death i ion and/or inve	estigation, in my opinion	on, death occurre	d at the time, date	and place, and due to	o the cause(s)
•	3		Id /Aleev	NV	_	102	2101) L	Date signed (Month,	2004
3.5	-01		30. Name and address of person who com 31. Date filed (Month, Day, Year)	wrsu un	147	5 tang	Mu.	ful.	ruck,	Md
	Star Registra		4.70.4	32. Registrar's Signate	ure	9 Ann	. 1/2/			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMENDED 4a,1/29/04,LDB,DOR Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Year Edwin harles aM5 :30 PM 2004 /Medical Jan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Koad WhiteMarsh entreville Anneis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dueen 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 18 M 2 □ F 38-118 62 Director 1941 Maryland Jan. 25. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County r than "naturel", or Items 23a or 28e-f show the Madical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No entre Ville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? temarsh Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ♣No Specify: φ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRINCipal 5+ 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil Iment of Health and Mental H tent: If item 27 is marked ott 18. Mother's Name (First, Middle, Maiden Surname) Lockwood Adams Brooks IO/a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu Centreville, MD, 21617 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Janet 20a. Method of Disposition 20c. Location - City Town, State 1 Burial 2 □ Cremation 3 □ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) he Sterfield Cemetery Centreville, Maryland 21/04 21. Signature of Funeral Service Licensee 22. Name and Address of Fi cility Henry Funeral Home, io washington St. Cambri Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 100000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): as the burial-transit the attending physician and Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death Day 5 Other (specify) detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð been si Completed 2 No 3 Probably 4 □Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? pace 2 has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Easton, MD

21601

509 Idlewild Avenue

32 Madstrar's Squature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Mary DeShields

31. Date filed (Month, Day, Year) AN 2

			1 - For State Registrar	State of Ma	aryland /		artment of H					4 02888
			Decedent's Name (First, Middle, Last,)			timodic or i	J C G 111		2. Date of Deat	wg. 140.	3. Time of Death
	Physic		Michael Croley	Barrett						Month January	Day Yea 7 13. 2004	r
Ĭ.	/Medi Examir		4a. Facility Name (If not institution, give				4b. City, Town, or	Location (oanuary	4c. County of De	
L			Frederick Memorial	Hospital	1		Frederi	ick			Frederi	.ck
A.	Funeral		5. Social Security Number 6. Set	x 7. Ag	e (In yrs. last b		If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	B. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		278-56-4660	2 W 2 U F	44	Yrs.				June 9,		rginia
	land wo		10a. State 10b. County		10c. City, To	wn or Lo	ocation					10d. Inside City Limits
	Mary F sh	ţ	Ohio Montgon	no rv	Eng1	01100	. d					1√2 Yes 2 No
	h the	Director	10e. Street and Number	icry	Lingi	EWOO	10f. Zip Code			1	0g. Citizen of What	Country?
	th wil	<u>a</u>	320 Oldham Way				45322				USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cubai	spanic Ori	gin? (Spec	ify Yes or No-		merican Indian,
36	s afte	by Ft	1 Never Married 2 Married	1 √ Yes 2 ☐ N If Yes, Give			1☐Yes 2√√ No	Specify:			Specify:	White
8	hour fural	ed b	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates: 1			dent's Usual Occupa	tion				
5	n 72	Completed	(Specify only highest grade	e completed)		(Give	kind of work done d DO NOT use retired,	furing mos	t of working	7	16b. Kind of Busines	ss/industry
27	d with	mo	Elementary/Secondary (0-12)	College (1-4or 5	0+)		le Worker				Constru	ation
9	al Hyg	Bec	17. Father's Name (First, Middle, Last)						er's Name (First, Middle, A	Maiden Sumame)	CULOII
<u>X</u>	Menti Menti arkad	10	Charles	В	Barrett			Mary	y A	Ann	Croley	
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Ty								City or Town, State	, Zip Code)
	1 and 1eaith am 27 ther t		MAry Ann Barrett/M	otner		-	1dham Way	Er	nglewo	ood, OH		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Pygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Exaciling relative relified at 900ce.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemet	ery, cren	natory or other place				20c. Location - City of	
┋	it. Partme		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	20	Frede	rick	Cremator	y C	01/14/	2004	Frederick	, MD
8	Depo Impo any r		Jack IMC	Do .		1	621 Onoss	11m + 01	yStaui m Pil	fer Fu	neral Homo derick, M	e, PA
			23a. Part 1 Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do							Approximate
	Physician		Immediate Cause (Final	111	1e.		Λ ι	0	_			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence	of):	Abnorn	N Sec	71_			24 hours
п	Examiner		Secure visits is coordinates	Renz	I Fi	du	æ					10 days
	D is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):						
	and and I-tran	xarr	that initiated events resulting in death) Last	Due to (c. as:	a onsequence	n off:	511					1000
8760	cate be executed chysicien and the burial-transit	dlcal E		Mult		01	Overdo	7(0)				10 dave
89	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	0			- 910	1	0 1-1-40					10 909
Box	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			[F-):-				23d. Date of de	elivery
	deat	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pregnancy Other <i>(specify)</i>				Month	Day Year
J.	at the de I by the a stached I	Phys	9 Unknown									
Ś	res that igned to be deta	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting	in the ur	iderlying cause give	n in Part I.				to the cause of death?
Hecords ,	w require been sig	eted	O GO = 1	ephaco	your	1			- N	1 L Yes	s 2□No 3□F	Probably 4 Unknown
9	has by	Completed	K621/1900	1 toll	ure '					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Vital			OS Man ages referred to the distant								ZNo 1□Ye	
		o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	ospital:	- 1 - ED/O		Othor		1-11	Check only one		
0	g Physer this eral di	\vdash	27. Manner of Death	28a. Date of Injur (Month, Day		Time of	28c. Injury	4 🗆 1901			nce 6 Other (Spenial of the second	ecify)
0	inding Fath. rr: After ie funera	atlo	1 □Natural 5 □ Pending 2 □ Accident investigation	January:	3.2004 L	2.0/1	M 1 Y	es 2,21	No 1	Atraver	rous Dru	a Use
DIVISION	r Atta er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	rv - At home fa	arm, stre	et, factory, office				et and Number or P	Rural Route Number,
2	ital o irs aff ral Di lled ir				mot					105 Kae	pTryst Rdt	MD 21758
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	er: On the basis of	examination ar	e, death nd/or inv	occurred at the time estigation, in my opi	e, date and nion, deatl	d place, and h occurred	I due to the cau at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	o the o the o the omple	Med	29b. Signature and title of certifier	and manner star	ted.		29c. License				d. Date signed (Mon	
,	⊢ ≱ ⊢ ŏ		X hand was	100			P35					
	5		30. Name and address of person who con	mpleted cause of de	eath (Item 23a)	(Type F	Print)					21,2004
			Dr. Andrew Zarick	151	D. 7th	15.	t. Fred	levi	de	MDZ	1701	
78	Sta		31. Date filed (Month, Day, Year)	32. Registre 2004 > 2	s Signature	la.	1.100					
	Registr	ar	JAN 2 8	2004	The second	D.	Gover					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Blake urdette Month Year erov 2115 AM Jan Mary
4b. City, Town, or Location of Death 21,2004 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4c. County of Death Mennonite Home Grantsville Garre 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 1 M 2□ F Hours Director Usual Residence of Decedent 10a. State rcident 10c. City, Town or Location item 27 is marked other than "netural", or items 23a or 28a-f sho other treumatic event, the Madical Examiner mast be profited at 10d. Inside City Limits Director 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No \$ Specify Specify: Whit 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pages 1 and 2 should be filed withi nent of Health and Mental Hygiene. ant: If item 27 Is marked other than College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any Injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Pneumonia /Medical Immediate Cause (Final disease or condition resulting in death) Week Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? dementia disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cerebrovascular Be Completed by cate has been sig , page 2 should b 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Tes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funerel director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 2 ☐ Accident 5 Pending investigation after death. Director: Aft 1 Yes 2 🗆 No the the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide To the Hospital of within 24 hours a To the Funerel D Medical 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Accident MD 21520

MD

90 BOX 247

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

January 21, 2004

TRS

31. Date filed (M. State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Naumann

DHMH 16 Rev 6/95

Amended #20b, nls, 1/23/04, Allegany Co

		1 - For State Registrar	State of Maryland / Dep	partment of Health are		ene 2004	02891
Physic	ian	1. Decedent's Name (First, Middle, Las	0		2. Date of Death Month	Day Year	3. Time of Death
/Med Exami		A. Christine Campbe 4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of	Death	4c. County of Deat	h
Funeral Director		5. Social Security Number 6. Se 216-38-1707		If Under 1 Year If Under 22 Months Days Hours	Hrs. 8. Date of Birth (Month, Day, 20-Dec-19	rear) Co	hplace (State or Forei untry) /land
Maryland -f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Allegan	10c. City, Town or to Cresaptown				10d. Inside City Limi
th with the 23a or 28a	ai Direc	10a Street and Number	enic View St., S.W.	10f. Zip Code 21502-		g. Citizen of What Co	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show say injury or other traumatic event. The Medical Examines from the Invitited at 2008.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 (Dr No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I		14. Race - Ame Black, White Specify: White	e, etc.
within 72 h ene. than "natu na Medical	mpletec	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	edent's Usual Occupation e kind of work done during most o DO NOT use retired) emaker	f working .	DD. KING OF BUSINESS!	ndustry
2 should be filed within and Mental Hygiene. is marked other than aumatic svent, Ina Me	To Be Co	17. Father's Name (First, Middle, Last) Lowrence Geiger	nome	18. Mother's	Name (First, Middle, Ma	omemaker aiden Sumame)	//
and 2 should saith and Men n 27 is marke	-	19a. Informant's Name/Relationship (T) John L. Campbell	урв, Print) 19b. Mail husband 14351 (ing Address (Street and Number of	/ Slinger or Rural Route Number, (resaptown	City or Town, State, Z	ip Code) 21502-
permit. Pages 1 and 3 Department of Health Important: If Item 27 sny injury or other tr. 90ce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ f '4 ☐ Donation 5 ☐ Other (Specify)	Terrioval fluiti State	osition (Name of matory or other place)		c. Location - City or 1	Town, State
permit. Departr imports sny inji		21. Signature of Funeral Service Licens	eurst Du	2. Name and Address of Facility Irst Funeral Home, 57	Frost Ave., Fros	itburg, MD 2	1532
Physician /Medical Examiner per partial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not en ne cause on each line. Left lung neoplas: Due to (or as a consequence of): Rheumatoid arthri Due to (or as a consequence of): Hypertension Due to (or as a consequence of):	m metastatic to	•		Approximate Interval Between Onset and Death 1 1/2 mo. 15 yrs.
death certifica e attending ph d for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
equires that en signed ould be de	Š	Part II. Other significant conditions con	ntributing to death but not resulting in the u	inderlying cause given in Part I.		2 No 3 Pro	the cause of death?
	Completed				24a. Was an autopsy performe	orior to co	opsy findings availatempletion of cause of
Physician: In this certificate ral director, pag	To Be	1 162 5 140	lospital: 1 Inpatient 2 ER/Outpatier	nt 3 DOA Other: 4 Nursin	Death (Check only one)	e 6 □Other (Speci	(y)
ing After une	ertification:	27. Mann: of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, str	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	at and Number or Run	al Route Number,
Hospital or Attand 24 hours after death Funeral Director: /	edical Cert	29a. Certifier 1 Certifying Phys	building, etc. (Specify) sician: To the best of my knowledge, deather: On the basis of examination and/or in and manuer, stated.	h occurred at the time, date and pi	City or Town, S	-(-)	tated.
To the Hos within 24 hr To the Fun completely		29b. Signature and title of certifier	and manner stated. Leccal Lectar (Item 23a) (Type,	29c. License number		Date signed (Month,	Day, Year)
MAS		DRUFIEL VELCO	included cause of death (Item 23a) (Type,	mint)	mberlang		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day **Physician** Lillie Ε. Caruso 15, 2004 January 12:45 pm /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Home Mount Airy Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Hours 1 □ M 2 X F Yrs. Director 578-20-2454 May 17, 1922 Illinois Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Merylend 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylen Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show with fulry or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🏖 No Directo Maryland Montgomery Germantown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 13321 Pepper Court U.S.A. 20874 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 집 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Program Specialist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin Schneider ဥ Rose Epps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Caruso - Daughter 13321 Pepper Court, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematorium Inc. 1/17/04 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** There sclevolic Carchovancular Discase /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physiclan/Medical Examiner or Attending Physician: The law requires that the deeth certificate be executed for use as the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events attending physician end Division of Vital Records, P.O. Box 68760, se5hire 00 Due to (or as a consequence of): resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 3 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No : After this certifice e funeral director, p 25. Was cese referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation ofter deeth.
I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗆 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 以 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) EILUMAN INE BALTIMOPLE MARKANIZIZIS SASAPATHI 3400 14 HMEH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 0 2004

			T = For State Registrar	State of	Maryland		artment of H Hificate of L		lental Hygie	/	la 02892
		r	Decedent's Name (First, Middle,	Last)			timouto or E	Joann	Reg. 2. Date of Death	. NO	3. Time of Death
ı	Physici			A11€	n L. Co	nisen				Day Yee 21 2004	3.4
}	/Medic Examin		4a. Fecility Name (If not institution,				4b. City, Town, or	Location of Death		4c. County of De	
			Shady Grove Adve	ntist Hos	pital			kville		Mon	tgomery
	Funeral			6. Sex 7 152 M 2 ☐ F	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	0.0	Sirthplece (Stete or Foreign Country)
-6	Director		Usual Residence of Decedent		76	Yrs.			July 24,1		ssachusetts
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Many	ţō	Maryland Mont	gomery	Germ	nantow	n				1 ☐ Yes 2 🛣 No
	n 188	Funeral Director	10e. Street and Number	8002	CCI	idireow	10f. Zip Code		10g.	Citizen of What	Country?
	th wit	aD	19515 Frederick	Road. # 1	51		2	0876	ι	Jnited S	tates
	ems erra	ner	11. Marital Status		dent Ever in U.S	3. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto			merican Indian,
36	within 72 hours alter death with the Maryland ene. then "natural" or items 23e or 28e-f ehow for Musileal Exercities result be notified at	by Fu	1 Never Married 2 Marrie	If Vac Give			I ☐ Yes 2☒ No	Specify:	,	Specify:	
21215-0036	hour tural	d b	3 Widowed 4 Divorced		tes: WWII	162 Door	lent's Usual Occupa	tion	100		White
Š	in 72 n "na	Completed	(Specify only highest	grade completed)		(Give	kind of work done d DO NOT use retired,	uring most of worki	ng	o. Kind of Busines	symdustry
212	y with	mo O	Elementary/Secondary (0-12)	College (1-	4or 5+)		Florist		R	Retail F	lorist
힏	al Hyg	Bec	17. Father's Name (First, Middle, L.	ast)				18. Mother's Name	(First, Middle, Main		
Maryland	Ments Ments arked	To	Bernard Cousen					Elizabet	h Mason		
lan	2 sho and ie ma		19a. Informant's Name/Relationshi			19b. Mailir	g Address (Street a	nd Number or Rura	l Route Number, Ci	ity or Town, State	, Zip Code)
	and lealth m 27		Betty J. Cousen	/ Wife	Look Di	19515	Frederic	ck Road,	# 151 Ger	mantown,	ма 20876
0	ges 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	3 □Removal from S	itate Ce	metery, cren	sition (Name of natory or other place	9)		c. Location - City of	or Town, State
Baltimore,	rtmen rtmen rtant: njury		* 4 ☐ Donation 5 ☐ Other (Special Signature of Fu (Special Service L.)	**	Gat		leaven Ce		26/04 Si	lver Spi	ring, Marylan
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show apportant your or other traumatic event, the Mudical Exercitive freat be notified at one.		21. Signature of Purpla Service L	Oly	m	01 26	Name and Addres in L. Mo 401 Ridge	lesworth Road, D	P. A., Fu amascus,	neral Ho Maryland	ome 1 20872
Е	1		23a. Part1. Enter the disease, or co shock, or heart failure. List of	omplications that cannot not one cause on ea	used the death ich line.	. Do not ent	er the mode of dying	, such as cardiac o	r respiratory arrest,		Approximate Interval Between
a	Physician		Immediate Cause (Final disease or condition	Bronc	hospasm						Onset and Death
Н	/Medical Examiner		resulting in death)		or as a consequ						1 40,73
ı	LXdiffiller	<u></u>	Sequentially list conditions,		nary Em						o days
	ted	nlne	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to to	ii as a consequ	ance or).					
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (c	or as a consequ	ence of):					
8760,	icate be executed physician and s the burial-transit	dical		d							
9	tifical ng ph as th	Medi									
Box	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnar		Ectopic pregnancy			23d. Date of d	
П	that the death certif ed by the attending detached for use a	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unknov	int at time of de		Other (specify)			Month	Day Year
P.O.	d by letach	Phy	Part II. Other significant condition	IR contributing to do:	ath but not room	lting is the	deshina anua au	n in Don't	220 Did tehne		to the cause of death?
Division of Vital Records,	sign sign d be					iding in the ta		mir an.		2 No 3 1	<u>,</u>
000	e law requ has been je 2 shouk	Completed							24a. Was an	24b. Were	autopsy findings available
œ e	The ate his page	E O							autopsy performed 1 ☐ Yes 2 ☑	death?	completion of cause of es 2 \sum No
Ha	ysician: The l is certificate ha director, page	Be (25. Was case referred to medical examiner?		,			26. Place of Death	(Check only one)		
2	hysicathus countries of the	2	1 Yes 2 No	-		R/Outpatien	3 □ DOA Othe	r. 4 Nursing Hor	ne 5 Residence	6 □Other (Sp	pecify)
Ĕ	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Injury , Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how in	njury occurred	
Sic	ttend death stor: / the f	cat	2 Accident investiga 3 Suicide 6 Could no	ot be	of laine. At hor	no fo		es 2 □No	194 l a-sti (Ot		
<u>></u>	al or A safter I Direc d in by	Certification;	4 Homicide determin	ed 200. Place of building	g, etc. (Specify))	eet, factory, office		City or Town, Si	tand Number or I tate)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: Alter this certifica completely filled in by the funeral director; p	edical	29a. Certifier 1 Certifying (Check only one) 2 Medicel E	Physician: To the baseminer: On the base	sis of examinati	vledge, death on and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the cause ad at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
	Fo the within Fo the comple	Med	29b. Signature and title of certifier	A			29c. License	number	29d.	Date signed (Mor	nth, Dey, Year)
	->-0) (Jestjan	+ 00 in) ini)	700	60168		Salmani	21,2004
			30. Name and address of pe on w	ho omplete cause	of death (Item	23а) (Туре,	Print)	20100		TNUTRY	611200
_	ID		1201 SEVEN	Locks R	-oad	Smite	2111.	Lockville	imb.	20854	
- 0	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signatu	ne /	1 house	,	, mb		

			For	Please T	• •		/ Depa	rtment o	Health and		•		_	. 02	2893
			1 - State Registrar				Cei	tificate c	of Death			eg. No.			
	Physici /Medic		Jerry E.	l1swort							Date of Dea Month Inuar	Day 7 19	7	5:	of Death
7	Examin		4a. Fecility Name (If no						n, or Location of De	eath			ounty of Dee		
			Frederick					Frede		drs o	Date of Birth		Freder		te or Foreign
	Funeral Director		5. Social Security Number 218-24-9545	1 🖾	M 2□F	ge (In yrs. Ia: 73	Yrs.	Months Da		lin.	eb 24	, Year)	Co	xville	
	and w		Usual Residence of De	b. County		10c. City,	Town or Lo	cation						10d. Inside	City Limits
	he Mary 28a-1 sho piilled	ector	MD 10e. Street and Number	Frederic	k .	Bru	nswic	10f, Zip Cod	lo.			Ing Citize	n of What Co		es 2□No
	23s or 2	Funeral Director	903 East	'C" Stree				217	16				USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. So injury or other traumatic event, the Medical Evancian must be notified at angle.	۵	11. Marital Status 1 ☐ Never Married 3 ☒ Widowed 4 ☐	2 Marned	2. Was Decedent Armed Forces: 1 XYes 2 I If Yes, Give Year or Dates:	No		Was Decedent f Yes, specify C I ☐ Yes 2☑	of Hispanic Origin? Cuban, Mexican, Pu No <i>Specify</i> :	' (Specif Jerto Ric	y Yes or No- an, etc.)		. Race - Ame Bleck, Whit pecify: Wi	e, etc.	,
Š	2 hou	Completed		. Decedent's Educ		T	16a. Dece	dent's Usual Oc	cupation	working		16b. Kind	of Business	/Industry	
215	thin 7 e.	ple		only highest grade ry (0-12)	College (1-4or	5+)	life.	DO NOT use re	ne during most of tired)	working	1		Railro		
21	ed wil	Con	Elementary/Seconda				Carm	an					swick,	MD	
Maryland	uld be file Aental Hy rked oth tic evant	To Be	17. Father's Name (Fin William I:		per				18. Mother's I		irst, Middle, a Darr		ımame)		
Mary	nd 2 shoulth and N		19a. Informant's Name						eet and Number of Road, Kno			-		Zip Code)	
nore,	ages 1 au nt of Hea nt: if Itsm / or othe		20a. Method of Dispos	remation 3 R	emoval from State	20b. Pla	ce of Disponetery, crer Wnsvi	sition (Name of natory or other 11e Hei	place) 1/2 ghts Ceme	23/2 eter	004		ition - City or		1
Baltimore,	permit. Po Departme Important eny injury poce.		*4 Donation 5.	ay Sarvice Licens	1020	an.			Idress of Facility Williams ISVILLE						_
	40244				liams, Ov								K, MD	Approxir	nate
	Physician /Medical Examiner		23a. Part1. Enter the shock, or heart fa Immediate Cause (Fin disease or condition resulting in death)			HISEM	A -	END - RIG	STAUL	7				SY	nd Death
	be executed sician and burial-transit	Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or inju- that initiated events resulting in death) Las	- C	Due to (or as			11701	(1)) CY(V V					,, <u>-</u>
	ate be exe hysician a he burial	ā	103 ditting in doutin, cas		Due to (or as	s a conseque	ence or):								
.O. Box 6	The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pr in the past 12 mc 1 □ Yes 2 □ N 9 □ Unknown	egnant inths?	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal o	death 3	Ectopic pregna Other (specify				230	d. Date of de Month	livery Day	Year
ls, P.	ires that t signed by I be deta		Part II. Other significe	nt conditions cor	tributing to death	but not resul	ting in the u	nderlying cause	given in Part I.		23e. Did to	_	contribute to	the cause	
Records,	law requir as been si 2 should	Completed								_	24a. Was a	ın :	24b. Were a		gs available
E.	ysician: The lav is certificate has director, page 2:	Com									perfor 1 ☐ Yes	med? 2 X No	death? 1 ☐ Yes		
Vital	Physician: r this certifica ral director, p	Be	25. Was case referred examiner?						26. Place of	Death (0	Check only or	10)			
Ž	Physic this ca al dire	ို	1 ☐ Yes 2 No	-	lospital: 1 Vinpat		R/Outpatier				5 🗆 Resid			cify)	
Division of	After After fune	atlon:	2 Accident	5 Pending investigation	28a. Date of Inj (Month, D	ay Year)	28b. Time o Injury		njury at Work? 1 □ Yes 2 □ No	280	f. Describe h	ow injury o	occurred		
Divis	al or Attendi s after death. Il Director: A od in by the fu	Certification:	3 🗍 Suicide 4 🔲 Homicide	6 Could not be determined	28e. Place of Ir building, e	njury - At hon etc. <i>(Specify)</i>	ne, farm, sti	eet, factory, off	ice	28f	. Location (S City or Tow		Number or R	ural Route N	lumber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 16 (Check only 25 one)	Certifying Phys	sician: To the bes ner: On the basis and manner s	of examination	ledge, deat on and/or in	n occurred at the	e time, date and pl ny opinion, death o	ace, and	due to the cat the time, o	ause(s) ar late and p	nd manner as lace, and due	s stated. to the caus	e(s)
	To the within 2 To the complet	Me	29b. Signature and titl	e of certifies	11			29c. Lic	ense number		2	9d. Date :	signed (Mont	th, Day, Yea	r)
			> New	(Waru	relita	Ms	22a) (T -	Print)	11074			JANI	20,	2004	7
1	2+1		30. Name and address	ARAVDE	KM 1	i an	475	TAN	EY AVE	# 3	109 F	REVIS	nice,	MD 2	1702
	Sta Regist		31. Date filed (Month,	JAN 2	1 2004	trar' Signatu	- B	Space	De la company						

		1	For Unpend Item # Registrar Decedent's Name (First, Middle,			U	ei uiica	ale OI I	veain		2. Date of D	eath		- 1	0 2 8 S
Physic				Cha	rles Ed	ward Ca	arrol.	1, Jr.	•		Month Janua		27, 2	Yeer	0437 A
/Med Exam		4	a. Fecility Name (If not institution,		i number)		4b. Ci	ty, Town, or	Location	of Death			c. County		
		L	22281 Nomoni S				1	onardi						Mary	's
Funera Directo			220-72-6700	6. Sex 1 [X]M 2 □		yrs. last birthda Yrs	Month	der 1 Year ns Days	If Under Hours	Min.	8. Date of B (Month, D December			Cou	plece (Stete or For ntry) 'yland
and and		_	suel Residence of Decedent Da. State 10b. County		100	c. City, Town or	Location								10d. Inside City Lin
r 28a-f ehow	ō	1	Maryland St. Ma	arv's		Leonard	itown								1 ☐ Yes 2√
with the Maryland a or 28a-f ehow	Director	10	De. Street and Number					Zip Code				10g. C	itizen of V	What Cou	ntry?
23a o			22281 Nomoni St	treet					2065	0		U	SA		
e	Funerai	1	1. Marital Status	12. Was I	Decedent Ever	in U.S. 1	3. Was Dec	cedent of Hi	ispanic Ori	igin? (Spe	ecify Yes or N	lo-		e - Ameri ck, White,	can Indian,
72 hours after des naturel', or Itams lical Examinarin	þ	•	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	ed 1 TY	es 2 🔯 No , Give or Dates:			2 √ No	Specify:		ricali, etc.)			Whit	
72 hours naturel',	etec		15. Decedent's (Specify only highest	s Education	ed)	16a. De	cedent's Us	sual Occupa	ation	t of worki	na	16b.	Kind of Bu	usiness/In	idustry
be filed within ital Hygiene. d other then event, its Me.	Completed		Elementary/Secondary (0-12)	7	ge (1-4or 5+)	life	B. DO NOT	use retired Cook)			Ме	rchant	t Mari	ine
d oth	Be	1	7. Father's Name (First, Middle, L						18. Mothe	er's Name	(First, Middle	e, Maide	n Sumam	e)	
	2		Charles E		roll, Sr					_	Kelley				
~ ~ ~ ~		11	9a. Informant's Name/Relationshi								I Route Numi				Code)
of Heelth Item 27 other tr		20	Rose Maria Carroll Da. Method of Disposition	/ Mother		Db. Place of Dis			e, A		e, Mary				own, State
ages nt of t: If it			1 ☑ Burial 2 ☐ Cremation		om State	cemetery, c	rematory of	r other plac		Jan	uary			•	
permit. Pages Department of It Importent: If Ite eny Injury or of once.		2	* 4 ☐ Donation 5 ☐ Other (Specific Lines) of Funeral Service Lines		7	harles Me		and Addres			2004	Leo	narato	own, M	laryland
Depa Impo eny li			In whool to	Les Ha	retinoi	4			ardine		eral Hom	ne. P	. A .		
		+	Charles 1				D 0 F		_			, -	• •		
		2	3a. Pert1. Enter the disease, of c	complications th	at caused the	death. Do not	P.O. F	3ox_270	Leon	ardto	wn Mary	7land	20650		Approximate
Physician		Ir	shock, or heart failure. List of mmediate Cause (Final	nly one cause of	on each line.		P.O. E	Sox_270 ode of dying	, Leon g, such as	ardto cardiac o	wn Mary	7land	20650		Interval Between
hysician /Medical		lr d	shock, or heart failure. List of	a	at caused the con each line. Atheroscle to (or as a con	erotic Ca	P.O. E	Sox_270 ode of dying	, Leon g, such as	ardto cardiac o	wn Mary	7land	20650		Interval Between
		lr d	shock, or heart failure. List of mmediate Cause (Final isease or condition ssulting in death)	a	theroscl	erotic Ca	P.O. E	Sox_270 ode of dying	, Leon g, such as	ardto cardiac o	wn Mary	7land	20650		Interval Between
/Medical Examiner	er	lr d	shock, or heart failure. List of mmediate Cause (Final isease or condition esulting in death)	a. Due	theroscl	erotic Cansequence of):	P.O. E	Sox_270 ode of dying	, Leon g, such as	ardto cardiac o	wn Mary	7land	20650		Interval Between
/Medical Examiner	er	India She SOth	shock, or heart failure. List of mmediate Cause (Final isease or condition esulting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat intitated events	a. A Due b. Due	Atherosc1	erotic Consequence of):	P.O. E	Sox_270 ode of dying	, Leon g, such as	ardto cardiac o	wn Mary	7land	20650		Approximate Interval Between Onset and Death
Medical Examiner ial-transit	Examiner	India She SOth	shock, or heart failure. List of mmediate Cause (Final isease or condition esulting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury	a. A Due b. Due	to (or as a con	erotic Consequence of):	P.O. E	Sox_270 ode of dying	, Leon g, such as	ardto cardiac o	wn Mary	7land	20650		Interval Between
Medical Examiner ial-transit	Examiner	India She SOth	shock, or heart failure. List of mmediate Cause (Final isease or condition esulting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat intitated events	a. A Due	Atherosc1	erotic Consequence of):	P.O. E	Sox_270 ode of dying	, Leon g, such as	ardto cardiac o	wn Mary	7land	20650		Interval Between
Medical Examiner ial-transit	Examiner	In de la constant de	shock, or heart failure. List of mmediate Cause (Final isease or condition southing in death) equentially list conditions, any, leading to immediate ause. Enter Underfying ause (Disease or injury lat initiated events southing in death) Last	a. Due	Atherosclito (or as a conto (or a) (or as a conto (or a) (or	erotic C: sequence of): sequence of):	P.O. E	Sox_270 ode of dying	, Leon g, such as	ardto cardiac o	wn Mary	7land	20650		Interval Between Onset and Death
death certificate be executed We attending physicien and purple of a still burial-transit	Examiner	In de la constant de	shock, or heart failure. List of mmediate Cause (Final isease or condition esulting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat initiated events esulting in death) Last	a	Atherosc1	erotic Casequence of): issequence of): issequence of): eggnancy Fetal death	P.O. E	Sox 270 ode of dying ascular	, Leon g, such as	ardto cardiac o	wn Mary	7land	20650	e of delive	Interval Between Onset and Death
death certificate be executed We attending physicien and purple of a still burial-transit	Examiner	Irrad on the care of the care	shock, or heart failure. List of mediate Cause (Final isease or condition saulting in death) equentially list conditions, any, leading to immediate ause. Enter Underfying ause (Disease or injury lat initiated events is ultimated events ause) (Escale of the condition of the con	a. Due b. Due d. 23c. If yes, 4 Pr	to (or as a conto (or a) (or as a conto (or a)	erotic C: asequence of): asequence of): asequence of): asequence of): asequence of): asequence of):	P.O. Fenter the minardiova	pregnancy	, Leon g, such as Disea	eardto cardiac o	wn, Mary	/land	20650 23d. Date Mor	e of delive	Interval Between Onset and Death
death certificate be executed We attending physicien and purple of a still burial-transit	by Physician/Medical Examiner	Irrad on the care of the care	shock, or heart failure. List of mediate Cause (Final isease or condition assulting in death) equentially list conditions, any, leading to immediate ause. Enter Underfying ause (Disease or injury lat initiated events issulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Due b. Due d. 23c. If yes, 4 Pr	to (or as a conto (or a) (or as a conto (or a)	erotic C: asequence of): asequence of): asequence of): asequence of): asequence of): asequence of):	P.O. Fenter the minardiova	pregnancy	, Leon g, such as Disea	eardto cardiac o	wn, Mary respiratory	/land	23d. Date Mor	e of delive	ery Day Year
Y requires that the death certificate be executed Way Deen signed by the attending physicien and Should be detached for use as the burial-transit	eted by Physician/Medical Examiner	Irrad on the second of the sec	shock, or heart failure. List of mediate Cause (Final isease or condition assulting in death) equentially list conditions, any, leading to immediate ause. Enter Underfying ause (Disease or injury lat initiated events issulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Due b. Due d. 23c. If yes, 4 Pr	to (or as a conto (or a) (or as a conto (or a)	erotic C: asequence of): asequence of): asequence of): asequence of): asequence of): asequence of):	P.O. Fenter the minardiova	pregnancy	, Leon g, such as Disea	eardto cardiac o	wn, Mar) r respiratory a	tobacco	23d. Date Mor	e of deliventh	ery Day Year The cause of death? About 1 Augus
Y requires that the death certificate be executed Way Deen signed by the attending physicien and Should be detached for use as the burial-transit	eted by Physician/Medical Examiner	Irrad on the second of the sec	shock, or heart failure. List of mediate Cause (Final isease or condition assulting in death) equentially list conditions, any, leading to immediate ause. Enter Underfying ause (Disease or injury lat initiated events issulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Due b. Due d. 23c. If yes, 4 Pr	to (or as a conto (or a) (or as a conto (or a)	erotic C: asequence of): asequence of): asequence of): asequence of): asequence of): asequence of):	P.O. Fenter the minardiova	pregnancy	, Leon g, such as Disea	eardto cardiac o	23e. Did	tobacco Yes 2 san psy	23d. Date Mor	e of deliventh ibute to the state of the st	ery Day Year ably 4 Unknot psy findings availa mpletion of cause of
Y requires that the death certificate be executed Way Deen signed by the attending physicien and Should be detached for use as the burial-transit	eted by Physician/Medical Examiner	Ird drivers of the second seco	shock, or heart failure. List of mediate Cause (Final isease or condition assulting in death) equentially list conditions, any, leading to immediate ause. Enter Underfying ause (Disease or injury lat initiated events issulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Due b. Due d. 23c. If yes, 4 Pr	to (or as a conto (or a) (or as a conto (or a)	erotic C: asequence of): asequence of): asequence of): asequence of): asequence of): asequence of):	P.O. Fenter the minardiova	pregnancy	, Leong, such as Disea	aardto cardiac o	23e. Did 1 24a. Was auto	tobacco Yes 2 ian psy 2 No	23d. Date Mor	e of deliventh ibute to the state of the sta	ery Day Year ably 4 Unknot psy findings availa mpletion of cause of
Y requires that the death certificate be executed Way Deen signed by the attending physicien and Should be detached for use as the burial-transit	eted by Physician/Medical Examiner	Ird drivers of the second seco	shock, or heart failure. List of mediate Cause (Final isease or condition southing in death) equentially list conditions, any, leading to immediate ause. Enter Underfying ause (Disease or injury lat initiated events in sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Pue b. Due c. Due d. 23c. If yes, 1 Lin 4 Pr 9 Ur us contributing to	to (or as a conto (or	erotic Casequence of): Issequence of):	P.O. Fenter the minardiova	pregnancy specify accuse give	n in Part I.	of Death	23e. Did 1 1 24a. Wate auto 150 Yes Check only	tobacco Yes 2 psy pormed? 2 No	23d. Date Mor	e of deliventh ibute to the state of the st	ery Day Year ne cause of death? ably 4 Dunkno psy findings availa mpletion of cause of 2 No
Y requires that the death certificate be executed Way Deen signed by the attending physicien and Should be detached for use as the burial-transit	eted by Physician/Medical Examiner	Ir de constant de	shock, or heart failure. List of mediate Cause (Final isease or condition saulting in death) equentially list conditions, any, leading to immediate ause. Enter Underfying ause (Disease or injury lat initiated events in the past 12 months? 1	a. Pue b. Due c. Due d	outcome of pre- egnant at time odeath but not lipatient ate of Injury	erotic Casequence of): Issequence of):	P.O. Earlier the minardiova	pregnancy specify)	n in Part I.	of Death	23e. Did 1 24a. Was auto	tobacco Yes 2 san psy pormed? 2 No	23d. Date Mor	e of deliventh ibute to the state of the st	ery Day Year ne cause of death? ably 4 Dunkno psy findings availa mpletion of cause of 2 No
Y requires that the death certificate be executed Way Deen signed by the attending physicien and Should be detached for use as the burial-transit	eted by Physician/Medical Examiner	Ir de constant de	shock, or heart failure. List of mediate Cause (Final isease or condition saulting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat intitated events is sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant condition 5. Was case referred to medical examiner? 1 Xes 2 No 7 No 9 No	a. Pue b. Due c. Due d. 23c. If yes, 1 Lih, 4 Pr 9 Ur us contributing to	to (or as a conto (or	erotic Casequence of): Issequence of):	P.O. Earlier the minardiova	pregnancy specify) cause give	n in Part I.	of Death	23e. Did 1 1 24a. Was auto perfu Yes Check only ne 5 \$\frac{1}{2}\$Res	tobacco Yes 2 san psy pormed? 2 No	23d. Date Mor	e of deliventh ibute to the state of the st	ery Day Year ne cause of death? ably 4 Dunkno psy findings availa mpletion of cause of 2 No
Y requires that the death certificate be executed Way Deen signed by the attending physicien and Should be detached for use as the burial-transit	eted by Physician/Medical Examiner	Ir de constant de	shock, or heart failure. List of mediate Cause (Final isease or condition saulting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat intitated events saulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant condition aximiner? 1 Xe 2 No 7 No 9 No	a. Pue b. Due c. Due d. 23c. If yes, 1 Lin 4 Pr 9 Ur us contributing to 128a. Da (M)	outcome of pre- egnant at time odeath but not lipatient ate of Injury	erotic Canada and a sequence of): again and a s	P.O. Earlier the minardiova	pregnancy specify) cause give	, Leong, such as Disea D	of Death	23e. Did 1 24a. Was auto perf. 15theck only ne 5 to Res. 8d. Describe	tobacco Yes 2 an psy ormed? 20 No	23d. Date Mor	e of deliveration of the state	ery Day Year ne cause of death? ably 4 Dunkno psy findings availa mpletion of cause of 2 No
Y requires that the death certificate be executed Way Deen signed by the attending physicien and Should be detached for use as the burial-transit	eted by Physician/Medical Examiner	Ir cc CC three cc	shock, or heart failure. List of mediate Cause (Final isease or condition saulting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat initiated events is sulfting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant condition art II. Other significant condition examiner? 1 Xes 2 No 7. Manner of Death Xecident S Pending Pen	a. Due b. Due c. Due d. 23c. If yes, 1 Link 4 Pr 9 Ur us contributing to the 28e. Plane	outcome of preventing ace of Injury a basis of example of the pass of the pass of the pass of the pass of the pass of the pass of example of the pass of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of the pass of example of example of the pass of example of exam	erotic Casequence of): Issequence of):	P.O. Earlier the minardiova 3 Ectopic	pregnancy specify) cause give	n in Part I. 26. Place 4 Nui at ?	of Death rsing Hon 2	23e. Did 1 24a. Was auto performed to the control of the control o	tobacco Yes 2 an psy ormed? 2 No	23d. Date Mor	e of deliveranth ibute to the state of the	any Year Day Year Day Year Day Year Day Year Day A Unkno
Y requires that the death certificate be executed Way Deen signed by the attending physicien and Should be detached for use as the burial-transit	eted by Physician/Medical Examiner	Ir cc CC three cc	shock, or heart failure. List of mediate Cause (Final isease or condition southing in death) equentially list conditions, any, leading to immediate ause. (Disease or injury lat initiated events is sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant condition 3. Was case referred to medical examiner? 1 Xeyes 2 No Namer of Death Xeyes 2 No Namer of Death Namer of	a. Due b. Due c. Due d	on each line. Atherosc1 to (or as a conto (or as	erotic Casequence of): Issequence of):	P.O. Earlier the minardiova	pregnancy specify) cause give	p. Leong, such as Disea	of Death rsing Hon 2	23e. Did 1 24a. Was auto performed to the control of the control o	tobacco Yes 2 an psy ormed? 2 No one how inju Street awn, State cause(s date an	23d. Date Mor use control of No 24b. When the second of No 24b. When the second of Normber 1 and Number 1 and	e of deliverable of the state o	any Year Day Year Day Year Day Year Day Year Day A Unkno
If Provisition: The law requires that the death certificate be executed to the law requires that the this certificate has been signed by the attending physicien and the principle in the burial-transit of the control	eted by Physician/Medical Examiner	Ir cc CC three cc	shock, or heart failure. List of mediate Cause (Final isease or condition saulting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat intitated events is ultimated events is ultimated events. Solve the saulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant condition art II. Other significant condition art II. Other significant condition investigation investigation investigation investigation investigation and investigation in	a. Due b. Due c. Due d. 23c. If yes, 1 1 Li, 4 Pr 9 Ur us contributing to the 28a. Da (Market) Physician: To the and m	on each line. Atherosc1 to (or as a conto (or as	erotic Casequence of): Issequence of):	P.O. Earlier the minardiova	pregnancy specify) cause give OOA Other 28c. Injury Work 1	p. Leong, such as Disea	of Death rsing Hon 2	23e. Did 1 24a. Was auto performed to the control of the control o	tobacco Yes 2 san psy primed? 2 No one idence how inju Street au wn, State cause(s date an	23d. Date Mor use control of No 24b. When the second of No 24b. When the second of Normber 1 and Number 1 and	e of deliverable of the state o	Pry Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year

Ple

ease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	1
State of Maryland / Department of Health and Mental Hygiene 2000	1 0

DAP	00100		For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of H <i>rtificate of l</i>			iene 200	4 02895	
ī	Physici		1. Decedent's Name (First, Midd Jeremiah		Emswiler			2. Date of Dea Month JANUARY	Day Yeo	3. Time of Death	
-	/iviedical						Location of Death	DEMORITA	4c. County of D		
*	- Examin	er	10690 FINGER E			Monrovi	ia		FREDERI	CK	
			5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)	
1	Funeral Director		220-02-9350	1 ∑ M 2□F	21 Yrs.	Months Days	Hours Min.	Oct. 1,	1982 Ma	aryland	
	D *		Usual Residence of Decedent 10a. State 10b. Count	v	10c. City, Town or Le	ocation				10d. Inside City Limits	
	Maryle f sho	ō							1 ☐ Yes 2 X No		
	72 hours after death with the Maryland natural; or Items 23s or 28s-f show acal Exambler mant be notified at	Director	10e. Street and Number	gomery	Damasco	10f. Zip Code		1	0g. Citizen of What	Country?	
		a D	27001 Lon	g Corner Roa	.d	2087	72		U.S.A	Α.	
		ıner	11. Marital Status	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.	
36	or It	y FL	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give		1 ☐ Yes 2X No	Specify:		Specify:	Vhite	
21215-0036	be filed within tal Hygiene. d other than event, the Mar	To Be Completed by Funeral	15. Decede	nt's Education	16a Dece	dent's Usual Occup	ation		16b. Kind of Busine	ss/Industry	
215			(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4o	(Give life.	kind of work done of DO NOT use retired	during most of work d)	ang [N	Montgomery Highway De	•	
			12		Tı	cainee				spar time is t	
Maryland			17. Father's Name (First, Middle Larry W. Em	swiler			18. Mother's Nam Kimbe		linix		
Z	hould id Men marke marke		19a. Informant's Name/Relation		19b. Mail	ng Address (Street a			, City or Town, Stat	e, Zip Code)	
Ma	nd 2 s lith an 27 is.		Kimberly M. Em			1 Long Co			•	cyland 20872	
re,	of Health If Item 27 or other tr		20a. Method of Disposition	0 TD	20b. Place of Disponentery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - City	or Town, State	
Baltimore,	permit. Pages Department of Important: If It any injury or o		1 Surial 2 ☐ Cremation 4 ☐ Conation 5 ☐ Other		e ·			21, 200)4 Damaso	cus, Maryland	
Salt	permit. Departr Import. any inju		21. Sign sture of F neral Service	e Licen ee) 02	2. Name and Addres	ss of Facility Lesworth	P.A., Fu	neral Hor	ne	
	70 E # 9		23a. Part1. Enter the disease,	- Willian	ns 26	6401 Ridge	e Road, D	amascus.	Maryland		
	Physician /Medical Examiner	n/Medical Exan iner	shock, or heart failure. Li	st only one cause on each	line.	ter the mode or dyin	ig, sucii as calciac	or respiratory arr	ost,	Interval Between Onset and Death	
1			disease or condition resulting in death)	a. Due to (or a	to consequence of):	dines					
				1	b						
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a							
	and traris		Cause (Disease or injury that initiated events resulting in death) Last	C	C						
60,	iclan: The law requires that the death certificate be execuled certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit		,	Due 10 (01 a							
68760,				d							
Вох			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		⊒Ectopic pregnancy	,		23d. Date of		
		slcla	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death 5	Other (specify)			Month	Day Year	
P.0		d by Physician/M	9 Unknown			indorhing causa aiv	on in Part I	23e Did to	hacco use contribut	e to the cause of death?	
ds,			Part II. Other significant conditions contributing to dealing at the anderlying cause given in tart.						Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown		
Records,		letec						24a. Was a	n 24b Were	autopsy findings available	
Rec		e Completed						autops perfor	sy prior med? death	to completion of cause of	
of Vital			25. Was case referred to medic	cal			26. Place of Dea	th (Check only or		795 2 NO	
5		OB	examiner? 1X Yes 2 ☐ No	Hospital: 1 ☐ Inpa	itient 2 ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing H	ome 5 Reside	ence \tag{5} ther (5	Specify) AT SCENE	
o	g Phys er this eral di	n: T	27. Manner of Death	28a. Date of In		of 28c. Injur			ow injury occurred	1.11.1	
Division	nding Fath. r: After	atlo	1 □Natural 5 □ Pend 21 □Accident inves	stigation YUS (04	1047		Yes 2 No	Sulye	A Plin	of yelling.	
Vis	Atte	ifle	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be 28e. Place of I	Injury - At home, farm, si etc. (Specify)	reet, factory, office		28f. Location (S. City or Town	treet and Number of	Rural Route Number,	
Ö	s afte	Certification:	Southern Martin to Count may la							wayland	
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	dical	29a. Certifier (Check only (Check only a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							r as stated. due to the cause(s)	
	o the o the omplet	Med	29b. Signature and title of certif	end manner ier	otaleC.	29c. Licens	e number	2	9d. Date signed (M	onth, Day, Year)	
	F ≱ F 8		11.0	11 10	/	OCM	E	i	JANUARY 1	6,2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
				Miking		Penn Stre	et, Balti	more, Ma	aryland 2	1201	
	Sta		31. Date filed (Month, Day, Yea	ar) 32. Regis	strar's/Signature	19 M	bouth				
42	Regist	ar	JF	117 6 U 20U	/-	1 /7					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ryland / Dep		Health and	Mental Hygi	3	02896	
	Physici	an	1. Decedent's Name (First, Middle, La MARILYN KAY					2. Date of Death Month JANUARY	Day Year	3. Time of Death 9:32 P M	
	/Medic Examir		DANUARI I						15 2004 4c. County of Dear		
	Exami	lei					ck	Frederi			
	Funeral		Social Security Number 6. 8	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year				thpleca (State or Foreign buntry)	
	Director		213-40-1977	1□M 2 X JF 6	8 Yrs.	Months Days	Hours Min	Jan.10,	1936 Ma	ryland	
36	and	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Maryl		Maryland Frederick Frederick						1 X Yes 2 ☐ No		
	r 28a		10e. Street and Number 10f. Zip Code 10g. Citizen of					g. Citizen of What Co	ountry?		
	within 72 hours after death with the Maryland ene. Than "hatural" or llems 23e or 28e-f show the Marsical Exmitter mant be notified at		2500 Waterside D	rive #103		21701		U	SA		
			11. Marital Status	12. Was Decedent Ex Armed Forces?	ver in U.S. 13.	Was Decedent of H	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit		
	s after		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐Yes 2★ No If Yes, Give		1 ☐ Yes 2 🛣 No Specify:			Specify: White		
8	hour		15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occup	nation	11	6b. Kind of Business/	Industry	
15	I within 72 ho iene. r than "natur the Moulcal		(Specify only highest gra	ade completed)	(Give	kind of work done DO NOT use retire	during most of we	orking	DC. Kind of Business	industry	
212	71 6 4 60		Elementary/Secondary (0-12)	College (1-4or 5+ 4	Nurs	e			Health Ca	are	
pu	be filed ital Hygi od other		17. Father's Name (First, Middle, Last)			18. Mother's Na	ime (First, Middle, Ma	aiden Sumame)		
yla			Maurice Elm	er Mill	er		Mildred	Naomi	0gle		
Maryland 21215-0036	and and ls m		19a. Informant's Name/Relationship (John R. Freeland/	* * * * * * * * * * * * * * * * * * * *		ng Address <i>(Street</i> Waterside		tural Route Number, 6	City or Town, State, 2 erick, MD		
	1 an Heal em 2 ther		20a. Method of Disposition	nusbanu	20b. Place of Dispo		e Diive i		Oc. Location - City or		
Baltimore,	of of the second		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, crei	natory or other pla	· 1		·		
Itin	글 원린 글 .		21. Signature of Funeral Service Lice					3/2004 Fr auffer Fun			
B	Permit. Departr Imports any inj		6 La Olian S	Sto Eson				Pike, Fred			
1	$f_{\mathcal{S}}$		23a. Part1. Enter the disease, or com	pplications that caused the	ne death. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory arres	it,	Approximate Interval Between	
	Physician	cal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as al consequence of):							Onset and Death	
	/Medical								July		
	Examiner		Sequentially list conditions.								
,092	pe jisi		Sequentially list conditions, If any, leading to immodiate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
	xecut and										
	ate be executed hysician and he burial-transit										
.89	ificate g phy as the										
Вох	death certificat e attending phy id for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy					23d. Date of delivery			
		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at til		Other (specify)	у		Month	Day Year	
P.O.	at the I by the	Phys	9 ☐ Unknown					- 1			
	es De es	To Be Completed by	Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	T .	cco use contribute to		
0	v requii been s should		aprial tiprillation 1 Yes						2 No 3 Probably 4 Unknown		
Vital Records,	The law sate has b page 2 s		hypo the to	14111				24a. Was an autopsy	prior to d	topsy findings available completion of cause of	
<u>e</u>			71 3		<u> </u>				d? death? ∃No 1 ☐ Yes	2 □ No	
	Physician: this certific ral director,		25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0 □ EB/O	A 2C DOA Oth		ath (Check only one)			
of	After fune		27. Manner of Death	28a. Date of Injury. 28b. Time of 28c. Injury at			ng Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
		atio	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes							rk? Yes 2 □ No	
ivis	r Attendi er death. rector: A	tiffic	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)			e, farm, street, factory, office 28f.			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	ital or rrs aft ral Di	Medical Certification:									
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier (Check only (Check only and manner as stated) (Check only (Check only and manner as stated) (Check only (Check only and manner as stated) (Check only (Check only and manner as stated) (Check only (Check only and manner as stated) (Check only (Check only and manner as stated)							stated. to the cause(s)	
	o the ithin 2 o the omple		one) and manner stated.						. Date signed (Month	, Day, Year)	
	⊢ 3 ⊢ ŏ		Ad HA	KINDENIA	1111	02	2101			() (0.4	
	1,5		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type.	Print)	100		inning /	0,100	
			Heyd Halu	WIN M	2 1475	tance	au.	tredo	rick in	121707	
	Sta	-0	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	4					
	Registr	वा ।	O PINU	U LUIU4 /	,	No della	METER STORY				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 16,2004 **Physician** FRED FRITZ January 10:09 PM /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Deeth Examiner 7507-A Hampton Valley Road Emmitsburg Frederick If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 x M 2 □ F 50 280-52-5071 February 18,1953 Director Ohio Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or Iteme 23s or 28s-f show event, the Medical Examiner must be notified at Emmitsburg Maryland Frederick 1 ☐ Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7507-A Hampton Valley Road 21727 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Engineering Elementary/Secondary (0-12) College (1-4or 5+) Bechtel Corp. marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be n and Mental h Winifred Walter Albert Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7507-A Hampton Valley Road, Emmitsburg, Maryland Christina Pax - Wife Department of Health a Important: If item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/22/2004 Frederick, Maryland 4 □ Donetion 5 □ Other (Specify) Frederick Crematory permit. 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility Stauffer Funeral Home harow Camelle 104 E. Main Street, Thurmont, Maryland 21788 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Laranoma ANCreatic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events attending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pg 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 ₹ No Dehydration peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy certificate 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To 28a. Date of Injury (Month, Day Year) 27. Manne of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Tyes 2 No death. after death 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Ö 12 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Dha h, Day, Year) JAN 22 32. Registrar's Signature 31. Date filed (Month, State 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 21, 2004 **Physician** EVELYN MARGUERITE FOX 2:45 PM/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dev. Year) Feb. 15, 1907 7. Age (In vrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 M 2 F Months Days Maryland 213-40-4418 96 Director Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County Show 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health end Mentel Hygiene. Internst 1 Hem 27 le marked other then "netural", or ttems 23a or 28e-f show ary or other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 HNo Director Maryland Frederick Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7407 Willow Road 21702 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☐No Specify: δ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Homer Emerson Waltz Golden Edith Mayne ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 s Depertment of Health er Important: If them 27 le u eny Injury or other treu once. James F. Fox (Son) 5681 Elser Drive, Chambersburg, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery 1/24/04 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or semplications that oadsed the death shock, or heart failure. List only one ceuse of each line. To not enter the mode of dying, such as cardiac or respiretory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ey monia Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records, ģ ruse (erotte Heart Dijuse 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No ours efter deeth.

erel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yes 2 → No 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending Netural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hosk within 24 hor To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 21,2004

Ninth St. Frederick MD 21701

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

ne

JAN 23

31. Dete filed (Month, Day, Year)

 \mathbf{II}

32. Register's Signature

Registrar

State

Suelyn M. Fax

CLINAL to Physicians as:

State of Maryland / Department of Health and Mental Hygiene 02899 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** John Philip Gue January 15, 2004 2:30 PM /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 10510 Moxley Road Damascus Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 1**X** M 2□ F Director 214-42-6214 June 2, 1944 59 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Damascus Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10510 Moxley Road 20872 U.S.A. Funeral 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 反 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Deputy Sheriff Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin L. Gue ۵ Ruth Souder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25915 Woodfield Road, Damascus, Maryland 20872 Helen S. Boyer - Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Departion 5 □ Other (Specify) Damascus Methodist Cemetery 1/20/04 Damascus, Maryland 21. Signature of Poperal Service Licensee 22. Name and Address of Facility
Olin L. Molesworth P.A., Funeral Home Munns overt 26401 Ridge Road, 20872-0117 Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Wound ned Examiner Due to (or as a consequence of) Examiner attending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai that initiated events resulting in death) Last Due to (or as a consequence of) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? certificate has been si irector, page 2 should 24a. Was an autopsy performed? Completed 1 🗆 Yes 2 X No 1 ☐ Yes 2D No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 □ No eral Director: After this certific filled in by the funeral director, To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28d. Describe how injury occurred that would 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Naturel Unknowed 1 ☐ Yes 2 No death. Unknown 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Tumber or Rural Route Number, City or Town, State) 10510 MMLE 9 ROAD DAMAS CWS, MARY LAND 2087 I 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office but ding, etc. (Specify) 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. edicai within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10ms 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) loms 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Herbert Howard Grimm January 21, 2004 10:30AM /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex †□ M 2□ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 220-26-5804 72 Sept. 1931 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Items 23a or 28a-f ahow the Medical Examiner must be notified at 1 X Yes 2 No Maryland Frederick Rocky Ridge by Funeral Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9911 Rocky Ridge Road 21778 U.S.A. death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Ite, any injury or other traumatic event, the Medical Examinat 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Korea Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Coltege (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Catoctin Mountain Park 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilbur M. Grimm Edna Danner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9911 Rocky Ridge Road, Rocky Ridge, MD 21778 Bessie D. Grimm 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Resthaven Mem. Gardens 1/25/04 Frederick, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Liceni ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that aus shock, or heart failure. List only one cause on the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) dex) **Physician** com; /Medical Due to (or as a consequence of) Examiner 9 Satuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ eq 0,0051 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 Drostate certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ____npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L To the Hospitel 29a. Certifier Sartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1209669 0 orr-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, Jr., 300 West 9th Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1100001	State of Maryland				-	iene	1
			1 - For State Registrar	Ciaic of Maryland		rtificate of L			a. No. 200	6 02902
			Decedent's Name (First, Middle, Last)	*****			1	2. Date of Deat	h	3. Time of Death
	Physici /Medic		VERA FLA	INE	J	OHNSO	ON	Month	Day Year 15 200	
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or			4c. County of De	ath
8			Harmany Hall 1			Colun			Howar	
	Funeral		5. Social Security Number 6. Sex 215 - 26 - 8927	M 20 F 7. Age (In yrs. la.	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) (irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	1 13	.,,			Oct. 4,	1730	MD.
	how how		10a. State 10b. County		Town or Lo	1 .				10d. Inside City Limits
	Ba-f a	ctor	md. Howar	d Co	lum	DIQ				1 DYes 2 □ No
	vith th	Olre	10e. Street and Number	Lane		10f. Zip Code	- / / /	10	Og. Citizen of What (
	illed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28e-f ahow ont, the Medical Exandract must be motified at	Funeral Director	4334	2. Was Decedent Ever in U.S.	12.1		044	acifu Vac ar Na		7 , nerican Indian,
'	fter d	F.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No If Yes, Give		Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Wh	
ğ	ral', o	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2☑No	Specify:		Specify: BI	ack
21215-0036	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done d	luring most of worl	king	16b. Kind of Busines	s/Industry
12	within ene. then	du	Elementary/Secondary (0-12)	College (1-4or 5+)	IITO. I	DO NOT use retired,	,		IRS	
0	Hygid Hygid Sther ent, I	ပိ	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, N	Maiden Sumame)	
Maryland	Hental Hental rked	To Be	Alfred C. W	leed on			Viola B	. Ranc	tolph	
ary	and N		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	a Address (Street a	and Number or Ru	ral Route Number	City or Town State	Zip Code) 21209
	and 2 eaith m 27		Paulette Stall	ing (niece)	1376	5 Tr/40	lelphia	Mill Re	1 Clarks	lille My
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28a-f ahow any injury or other traumatic event, the Medical Examinating must be notified at once.		20a. Method of Disposition 1☑Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	netery, crer	sition (Name of natory or other place	9)		20c. Location - City o	
Ħ	it. Pa rtmen rtant: njury		"4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		e hill	Cem.	Jan 20	,04 1	Freelerich	rna
Ba	Depa Impo eny i		Say X- Gil	len	60	west	ilws Free	st frede	one Mid	21701
*			23a. Part1. Enter the disease, of complice shock, or heart failure. List only on	cations that caused the death.						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Congesti	ve 1					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):					
		j.	Sequentially list conditions, if any leading to immediate	End Stage Due to (or as a conseque	once of):	enal ois	sease			Years
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Huperter						Years.
oʻ	te be executed ysician and le burial-transit		resulting in death) Last	Due to (or as a conseque						
8760,	2 2 9	lical	C _d							
x 68	ding p	/Mec	IF FEMALE:	Bc. If yes, outcome of pregnance						
P.O. Box	that the death certifica ed by the attending ph detached for use as th	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
o.	t the d by the ached	hysi	1 □ Yes 2 ØNo 9 □ Unknown	9☐ Unknown						
	w requires that been signed be should be det	oy P	Part II. Other significant conditions con	ributing to death but not result	ing in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ğ	equire ien siç ould b	ted	Dementia			-		1 🗆 Yes	s 2□No 3□F	Probably 4 Unknown
Vital Records,	a % C/	Completed by Physician/Med	Aostic Ste	nosis				24a. Was an autopsy	/ I orior to	autopsy findings available completion of cause of
E	cate f	Con						perform 1 ☐ Yes 2	ed? death? ENo 1□Ye	s 2 No
Ĭ	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗙 No	ospital:		Othe		h (Check only one		
o	Phys ar this aral dir	7: To	27. Manner of Jeath	28a. Date of Injury 2	8b. Time of	1 3LI DOA	4 Li Nursing Ho	ome 5 ☐ Resider 28d. Describe how	nce 6 Other (Sp	ecify)
o	nding ath. r: Afte	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? ′es 2 □ No			
Division of	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	oital o urs afi aral Di									
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Madical Exemin	ician: To the best of my knowler: On the basis of examinationand manner stated.	edge, death n and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	201.00		29c. License		. 29	d. Date signed (Mor	
•				Juma		D5	8747		01.50	.04
1	O		30. Name and address of person who con	and the same of th			Cal	D4-	0.00	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	501te	200	Columb	ia M.	0 2101	44
\$	Registr	_	JAN 21	2004 Daner	a	& So	ne No 1			
							11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			

		1 - For State Registrar	State of Mary	land / Depa		Health and	Mental Hygi	•	0290
Physici /Medio Examin	al	Decedent's Name (First, Middle, Las DAVID EDISOI Aa. Facility Name (If not institution, give 110 LEFEVRE I	KIRK street and number)		4b. City, Town,	or Location of Deatl		4c. County of Dea	
Funeral Director		5. Social Security Number 216–18–1297 Usual Residence of Decedent	7. Age (In 79)	yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, JUNE 27,	(ear) 9. Bir	thplace (State or Foreig ountry) ARYLAND
hours after death with the Maryland turel', or Itams 23a or 28a-f show al Examiner must be indiffed at	Director	10a. State 10b. County MD ALLEGA 10e. Street and Number		c. City, Town or Lo					10d. Inside City Limits 1 XYes 2 □ No
th with 23a or	al Dir	110 LEFEVRE RO	AD		2150	2	10	U.S.A.	ountry?
be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or Itams 23a or 28a-1 show event, the Medical Evanties must be todified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
within 72 ho lene. than "natur the Medical I	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wor ed)	king	6b. Kind of Business	/Industry
ild be filed wit lental Hygiene ked other the ilc event, the	Be	12 17. Father's Name (First, Middle, Last)		ТА	X ASSES	1	ne (First, Middle, Ma		MARYLANI
should nd Men marke imatic	2	JOHN KIRK, SR. 19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Stree		C. RUSS	SELL City or Town, State, .	Zip Code)
and 2 ealth a n 27 ls		ROBERT HARVEY KIT		1 24				VALE, MID	
Pages 1 nent of H int: if ite iry or oti	. 3	20a. Method of Disposition 1	Removal from State	cemetery, crei	natory or other pia	ARK 01/2			
permit. Pages 1 Department of H Important: if ite any injury or ott		21. Signature of Funeral Strvice Licenses of Company of Funeral Strvice Licenses of Company of Comp	s e /	22	. Name and Addr	ess of Facility	TOUR D.	CUMBERLAN •	21502 Approximate
eath certificate be executed Examination physician and attending physician and for use as the buriat-transit	icai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to intrinduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A.S.C.V. Due to (or as a cor Hyperter Due to (or as a cor Due to (or as a cor d.	nsequence of): NSION					
The law requires that the death certifica tte has been signed by the attending phy bage 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death 3	Ectopic pregnanc Other (specify)	cy .	-	23d. Date of del Month	ivery Day Year
quires that n signed by ald be deta	d by Ph	Part II. Other significant conditions co	ntributing to death but no	t resulting in the ur	nderlying cause gr	ven in Part I.		cco use contribute to	the cause of death?
(0)	Completed						24a. Was an autopsy performe	q? death?	topsy findings available completion of cause of 2 No
ing Phys n. After this funeral dii	ation; To Be	25. Was case referred to medical examiner? Yes 2 No 27. Manner of Death Notural 5 Pending Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 ☐ Nursing Hory at	th (Check only one) ome 5 (Residence 28d. Describe how	e 6 Other (Special injury occurred	cify)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, streecify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Hospi 24 hour Funer stely fill	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death nination and/or inv	occurred at the ti restigation, in my o	me, date and place, opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated, to the cause(s)
To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of ceptifier	And married stated.	An-	29c. Licens	se number 0 9/5 7	29d	Date signed (Month	n, Day, Year) 3004
MUS		3 ame and address of rs who c	Deputy M 32. Registrar's S	E. 124	W. Thin	1 St. Cum	nberland,	MD 21	502
Sta Registra		JAN 2 3 20	04	AS G	Soon	61			

			1 - For State Registrar	State of Maryland		nt of Health and N e of Death	lental Hygie	/ IIII la	02904
5	Physici /Medic	al	Decedent's Name (First, Middle, Las LLLAM	SORN LEE	JR.	Town, or Location of Death	JAN. 1	Day Year 1 2 C 4 4c. County of Death	3. Time of Death
	Examin Funeral Director	er	98 McMuRA 5. Social Security Number 6. Se	Ay ST	FR	EDERICK 1 Year If Under 24 Hrs.	8. Date of Birth	ar) 9. Birth	place (State or Foreign ntry)
		tor	Usual Residence of Decedent 10a. State 10b. County ACT	1	Town or Location	12	11.11.7		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the Marylan 8 23a or 28e-f show wat be notified at	Funeral Director		RAMY ST	10f. Zij	21701		Citizen of What Cou	4.
9036	hours after death with the Maryland lural', or Items 23a or 28e-f show at Examinat must be nutified at	۵	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Let'es 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes		Rican, etc.)	14. Race - Ameri Black, White, Specify: BL	ACK
21215-0036	s within 72 piene. r than "nat	Completed	15. Decedent's Ed (Specify only highest gran Elementary/Secondary (0-12)		16a. Decedent's Usu (Give kind of wo life. DO NOT u	ork done during most of work se retired)	sing	o. Kind of Business/Ir	ndustry
Maryland	d 2 should be filed h and Mental Hygi 7 is marked other traumatic event,	To Be (17. Father's Name (First, Middle, Last) LUI LLIAM (75/) 19a. Informant's Name/Relationship (7	ORN LEE,	SR.	18. Mother's Nam	B. Haller Maidele, Ma	LANd	p Code)
_	s 1 and 2 s f Health an Item 27 is other trau		CYNTHIR LEE	= (WITE)	98 MG	MURRAY	ST. FRE	0 100.	21701
Baltimore	0 0 = =		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ce of Disposition (Na netery, crematory or RIII C	other place)	6-04 F	Location - City or T	1/3.
Balti	permit. Pag Department Importent: I any injury c		21. Signature of Funeral Service Licen	ollin	1104		ST Frie	LLINS FR.	21701
7	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heaft failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. a.	prate	de of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	licai Examiner	Sequentially list conditions, if any, seating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	7 5 / CF nce oi).	1075	C-7 = c		9 mo
.O. Box 6	at the death certifice by the attending pr tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal di 4 □ Pregnant at time of deal 9 □ Unknown	eath 3 □Ectopic p			23d. Date of deliv Month	rery Day Year
Δ.	quires that I en signed by uld be deta	þ	Part II. Other significant conditions of	ontributing to death but not resulti	ing in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to t	
al Records,		Completed				20.0148	24a. Was an autopsy performed 1 ☐ Yes 2	prior to co	opsy findings available ompletion of cause of
of Vital	Physician: 1 this certifical ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		R/Outpatient 3 ☐ D	OA Other: 4 Nursing H	th (Check only one) ome 5		fy)
	ling After une	ation:	27. Manner of Math 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	8b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	liury occurred	
Division	ire in	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factor	y, office	28f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
	To the Hospitel of within 24 hours at To the Funeral D completely filled it	edical		ysician: To the best of my knowle niner: On the basis of examination and manner stated.					
	To th within To th	Me	29b. Signature and title of certifier	71	29	c. License number		Date signed (Month,	
	·		30. Name and address of person who	completed cause of death (Item 2	23a) (Type, Print)	D1462C		19,	D21701
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2	32. Registrar's Signatur 0 2004	re by	Sparks	TRUCA	nce 11	WZINI

			For	State	of Marylar	nd / Dep	artment o	of Health	and M	ental Hyg	iene	01	00000
_			1 - For State Registrar			Ce	rtificate (of Death	7	R	g. No.	U H	CUEZU
П	Physici	an	Decedent's Name (First, Mido	lle, Last)			-			2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic		Elsie		May		McDona			Jan.	20	04	12:25 PM
	Examin	er	4a. Fecility Name (If not institution	11			4b. City, Tow	vn, or Location		/	4c. County		
	F		Social Security Number	6. Sex	7. Age (In yrs.	last birthday	If Under 1 Y	m Der		8. Date of Birth	17	lleg	Q N V
	Funeral Director		217-10-5107	1 □ M 2XCXF	90	Yrs.		ays Hours	Min.	3/26/1	913	Mary	ntry)
	D		Usual Residence of Decedent				1						
	arylar show	J.	10a. State 10b. County		10c. Ci	ity, Town or Le	ocation					1	10d. Inside City Limits 1 XYes 2 ☐ No
	the M	ecto	MD A	11egany		Cumber		4.				140 1 2	
	with la or :	Dir	465 Independe	nco Stroo	.+		10f. Zip Coo	1502		1	Og. Citizen of USA	What Cou	ntry?
	within 72 hours after death with the Maryland ene. than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Decedent If Yes, specify (rigin? (Spec	cify Yes or No-		e - Americ	can Indian,
9	or Ite	Fu	1 ☐ Never Married 2 ☐ Mar	rried 1 Yes	2XXNo					Rican, etc.)	Bla	ck, White,	
ဗ္ဗ	ural',	d by	XXWidowed 4 □ Divorced	If Yes, G Year or	Dates:		1□Yes 2DX	No Specify.	:	_	Specif	y: W	hite
21215-0036	"natu	Completed		nt's Education est grade completed	()	16a. Dece (Give	edent's Usual Od kind of work do DO NOT use re	ccupation one during mos	st of workin	g	16b. Kind of B	usin <i>e</i> ss/In	dustry
12	withir ene than	ш	Elementary/Secondary (0-12)	College	(1-4or 5+)			etired)			m		
	Hygi Other ont,	Be Co	17. Father's Name (First, Middle,	Last)		J. La	borer	18. Moth	er's Name	(First, Middle, N		xtile ne)	
an	Aenta Aenta rked tlc ev	To B	Henry		Bock	house		Bert	tha	Kathe	erine	Da	vis
Maryland	2 short		19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address (Str	reet and Numb	er or Rural	Route Number,	City or Town,	State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Norman L. McDo	nald / sc						e, Cumbe			21502
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from	20b. I	Place of Dispo cemetery, crei	osition (Name o matory or other	place)	Da	ate	20c. Location	City or To	own, State
Ē	t. Partmen		`4 □Donation 5 □Other (S		St		's Ceme			/2004	Cumber		
Ba	Depariment of the police of th		21. Signatur of uneral Service	Licensee	٨	22					-		Home, P.A.
			23a. Part1. Enter the disease, o	r complications that	caused the deal	th. Do not ent				et, Cuml		1, MD	21502 Approximate
П	Physician		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on	each line.								Interval Between Onset and Death
		1	disease or condition resulting in death)	_ a. (Ø	$2 \cap OP$	000	\sim						20000
100	∞ /Medical]	,	Due to	o (or as a consec	uence o):	ALLICOL	4 pr	801	280			10 graes
*	Examiner			Due to		9 MM	ACCION ACCIONA	7 61	801-	380			4 YEARS
· · · · ·	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	h C		9 My	40 DOCT	the state	<i>3</i> 01-	380			4 years
100	Examiner	xaminer		b Due to	(or as a consec	9 MA	400cT	thy	301-	380			4 years
,09	Examiner	ai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Oue to	ARD.	9 MA	400cT	thy and	3C1-	380			4 years
00	Examiner and sician and purial-transit	edicai	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to	(or as a consec	9 MA	doc-	ny ar	301 -				4 years
ox 68760,	Examiner and sician and purial-transit	edicai	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Due to	o (or as a consecutive of pregnature of pregnature)	quence of):),,,	thy and	<i>SC1</i> -		23d. Da	te of delive	4 years
. Box 68	Examiner and sician and purial-transit	edicai	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Ves} \) 2 \(\text{No} \) No	c. Due to d. 23c. If yes, or 1 Live 4 Preg	o (or as a consection of pregnibirth 2 Feta	quence of): ancy al death 3	Ectopic pregna		3C1-		23d. Dai		4 years
.O. Box 68	Examiner and sician and purial-transit	edicai	Fequentially set conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to	o (or as a consecution of pregnation of pregnant at time of conown	quence of): ancy al death 3 [death 5 [⊒Ectopic pregna □ Other (specify	·)	36.1 -		Мо	nth	ary Day Year
P.O. Box 68	es that the death certificate be executed gned by the attending physician and be detached for use as the burial-transit	by Physician/Medical	Fequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Pert II. Other significant conditi	c. Due to	o (or as a consecution of pregnation of pregnant at time of consecution of the consecutio	quence of): ancy al death 3 [death 5 [⊒Ectopic pregna □ Other (specify	·)	SC1 -		Mo acco use cont	nth ribute to th	ery Year Day Year
P.O. Box 68	es that the death certificate be executed gned by the attending physician and be detached for use as the burial-transit	by Physician/Medical	Fequentially set conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to	o (or as a consecution of pregnation of pregnant at time of conown	quence of): ancy al death 3 [death 5 [⊒Ectopic pregna □ Other (specify	·)	SC1 -	1 □ Ye	Mo acco use cont s 2 %o	nth ribute to th 3 ☐ Prob	ary Day Year ne cause of death? ably 4 □Unknown
P.O. Box 68	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical	Fequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Pert II. Other significant conditi	c. Due to	o (or as a consecution of pregnation of pregnant at time of consecution of the consecutio	quence of): ancy al death 3 [death 5 [⊒Ectopic pregna □ Other (specify	·)	SC1 -	1 ☐ Ye	Acco use cont	ribute to th	ery Year Day Year
Records, P.O. Box 68	The law requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit or the control of th	Completed by Physician/Medical	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Pert II. Other significant conditions to the conditions of the conditions of the cause of th	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkr	o (or as a consecution of pregnation of pregnant at time of consecution of the consecutio	quence of): ancy al death 3 [death 5 [⊒Ectopic pregna □ Other (specify	e given in Part I		1 Ye 24a. Was ar autopsy perform 1 Yes 2	Modacco use control s 2 Modacco use control s 2 Modacco use control s 24b. V	ribute to th	Day Year ne cause of death? ably 4 Unknown psy findings available inpletion of cause of
Vital Records, P.O. Box 68	reician: The law requires that the death certificate be executed to sertificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit of	o Be Completed by Physician/Medical	Sequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkr	o (or as a consection of or as a consection of or as a consection of or as a consection of or as a consection of or as a consection of or as a consection of or as a consection of or as a consection of or as a consection or as a consection of or as a consection of or as a consection or as a consection of or as a consection of or as a consection or as a consection of or a consection of or a consection of or a consection of or a consection of or a consection of or a consection of or a consection of or a consection of or a consection of or a consection of or a consection of or a consection of or a consection or a	quence of): ancy al death 3 [death 5 [□Ectopic pregna □ Other (specify nderlying cause	26. Place	of Death	1 Ye 24a. Was ar autopsy perform 1 Yes 2	Modern Mo	ribute to the series of the se	Day Year Day Year Day 4 Unknown psy findings available mpletion of cause of 2 No
of Vital Records, P.O. Box 68	hysician: The law requires that the death certificate be executed the continuate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit of	To Be Completed by Physician/Medical	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkr ons contributing to Hospital: 28a. Date	o (or as a consect of or as a co	quence of): ancy al death 3 [death 5 [death 5 [death 5 [death 5]	□Ectopic pregna □ Other (specify Inderlying cause Int 3□ DOA If 28c, It	26. Place Other: 4 \(\) Nu	of Death ,	1 Ye 24a. Was ar autopsy perform 1 Yes 2	Modacco use continues 2 100 24b. 100 24b. 100 24b. 100 200 200 200 200 200 200 200 200 200	nth ribute to th 3 □ Prob Were autoprior to condeath? □ Yes er (Specify)	Day Year Day Year Day 4 Unknown psy findings available mpletion of cause of 2 No
of Vital Records, P.O. Box 68	hysician: The law requires that the death certificate be executed the continuate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit of	To Be Completed by Physician/Medical	Sequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkr ons contributing to Hospital: 28a. Date (Mor	o (or as a consect of or a consect of or a consect of or a consect of	quence of): ancy al death 3 [death 5 [sulting in the u	□Ectopic pregna □ Other (specify nderlying cause at 3□ DOA f 28c. In	26. Place Other: 4 Nu	of Death oursing Hom 28	1 Ye 24a. Was ar autopsy perform 1 Yes 2 (Check only one e 5 Resider	Modacco use continues 2 100 24b. 100 24b. 100 24b. 100 200 200 200 200 200 200 200 200 200	nth ribute to th 3 □ Prob Were autoprior to condeath? □ Yes er (Specify)	Day Year Day Year Day 4 Unknown psy findings available mpletion of cause of 2 No
of Vital Records, P.O. Box 68	Ittending Physician: The law requires that the death certificate be executed death. death. ctor: After this certificate has been signed by the attending physician and it the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	To Be Completed by Physician/Medical	Sequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d. 23c. If yes, or 1 line to 1 line to 2 line to	o (or as a consect of or as a co	quence of): ancy al death 3 [death 5 [death 5 [death 5 [death 5 [death 5 [death 5 [death 5 [death 5 [death 5 [death 5 [death 5 [death 6 [death	□Ectopic pregna □ Other (specify) Inderlying cause Int 3□ DOA If 28c. It	26. Place Other: 4 Nu njury at 1 Yes 2	of Death oursing Hom 28	24a. Was an autopsy perform 1 Yes 2 (Check only one 5 Resider and Describe hore)	ed? No 24b. \ 24b. \ No 24b. \ 100 100 100 100 100 100 100 10	nith 3 Prob Prob Pere autoprior to condeath? Yes er (Specify ed	Day Year Day Year Day 4 Unknown psy findings available mpletion of cause of 2 No
of Vital Records, P.O. Box 68	Ittending Physician: The law requires that the death certificate be executed death. death. ctor: After this certificate has been signed by the attending physician and it the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	Certification: To Be Completed by Physician/Medical	Sequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkr ons contributing to Hospital: 28a. Date (Mor gation not be nined 28e. Place	o (or as a consect of or a consect of or a consect of or a consect of	ancy al death 3 death 5 death	Description of the control of the co	26. Place Other: 4 Nu niury at Work? 1 Yes 2	a of Death ursing Hom 28 No	24a. Was an autopsy perform 1 Yes 2 (Check only one 5 Resider and Describe how at Location (Str. City or Town,	Acco use cont s 2 No 24b. 1 S 2 No 1 S 2 No 1 S 2 No 1 S 2 No 1 S 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2	nith 3 Prob Nere auto prof to cordeath? Yes er (Specif) ed	any Day Year ne cause of death? ably 4 Unknown psy findings available mpletion of cause of 2 No I Route Number,
of Vital Records, P.O. Box 68	Ittending Physician: The law requires that the death certificate be executed death. death. ctor: After this certificate has been signed by the attending physician and it the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	Certification: To Be Completed by Physician/Medical	Fequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Pert II. Other significant conditions of the conditions	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkr ons contributing to Hospital: 28a. Date (Mor gation not be ined 28e. Plac build ag Physician: To the Examiner: On the b	o (or as a consect of or as a co	quence of): ancy al death 3 [death 5 [death 5 [death 5 [death 5] ER/Outpatien 28b. Time of Injury ome, farm, str	Declaration of the concurred at the	26. Place Other: 4 \(\) Nu njury at Work? 1 \(\) Yes 2 \(\)	a of Death oursing Homores	24a. Was an autopsy perform 1 Yes 2 (Check only one 5 Resider and Describe how City or Town, and due to the care	Mo acco use cont s 2 No 24b. \ ed? No ce 6 □Oth v injury occurr	nith sribute to the stribute to the stribute to the stribute to the stribute to construct the stribute to the	Pary Day Year The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death?
of Vital Records, P.O. Box 68	Ittending Physician: The law requires that the death certificate be executed death. death. ctor: After this certificate has been signed by the attending physician and it the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	To Be Completed by Physician/Medical	Sequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unker ons contributing to Hospital: 28a. Date (Mor gation not be ing Physician: To the Examiner: On the is and mar	utcome of pregnibirth 2 Feta prant at time of chown death but not resuppatient 2 death but not resuppat	quence of): ancy al death 3 [death 5 [death 5 [death 5 [death 5] ER/Outpatien 28b. Time of Injury ome, farm, str	Deet, factory, offin occurred at the vestigation, in m	26. Place Other: 4 \(\) Nu njury at Work? 1 \(\) Yes 2 \(\)	a of Death oursing Homores	24a. Was an autopsy perform 1 Yes 2 (Check only one 5 Resider and Describe how to the Cathor City or Town, and due to the cathor dat the time, dated	Mo acco use cont s 2 No 24b. \ ed? No ce 6 □Oth v injury occurr	nith sibute to the strict of	Pry Day Year The cause of death? The cause of dea
of Vital Records, P.O. Box 68	Attending Physicien: The law requires that the death certificate be executed or death. r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit or	edical Certification; To Be Completed by Physician/Medical	Fequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkr ons contributing to Hospital: 28a. Date (Mor gation not be gation not be ting Physician: To the Examiner: On the tand man or	utcome of pregnibirth 2 Feta prant at time of chown death but not resuppatient 2 death but not resuppat	quence of): ancy al death 3 [death 5 [death 5 [death 5 [death 5] ER/Outpatien 28b. Time of Injury ome, farm, str	Detropic pregnary Other (specify) Int 3 DOA f 28c. In M reet, factory, offine to occurred at the vestigation, in m 29c. Lice	26. Place Other: 4 Nu njury at Work? 1 Yes 2 ice e time, date an ny opinion, dea	a of Death oursing Homores	24a. Was an autopsy perform 1 Yes 2 (Check only one 5 Resider and Describe how to the Cathor City or Town, and due to the cathor dat the time, dated	ed? No 24b. \ 24b. \ No 24b. \ 100 ed? No ce 6 \ 100 cet and Numb State) use(s) and male and place, and d. Date signed	nith all Prob Were auto prior to cor feath? Yes er (Specif) ed nner as st and due to	Pay Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year
of Vital Records, P.O. Box 68	Ittending Physician: The law requires that the death certificate be executed death. death. ctor: After this certificate has been signed by the attending physician and it the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	edical Certification; To Be Completed by Physician/Medical	Fequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unker ons contributing to Hospital: 28a. Date (Mor gation not be 28e. Plac build ng Physician: To the Examiner: On the to and man	utcome of pregnibirth 2 Feta prant at time of chown death but not resuppatient 2 death but not resuppat	quence of): ancy al death 3 [Jeath 5 [Sulting in the unit of the line of th	DEctopic pregna Other (specify nderlying cause of the second of the seco	26. Place Other: 4 Nu njury at Work? 1 Yes 2 ice e time, date an ny opinion, dea	a of Death oursing Homores	24a. Was an autopsy perform 1 Yes 2 (Check only one 5 Resider and Describe how to the Cathor City or Town, and due to the cathor dat the time, dated	Mo acco use cont s 2 No 24b.) ed? No ce 6 Oth vinjury occurr use(s) and ma e and place, a d. Date signed	nith sibute to the strict of	Pay Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year
of Vital Records, P.O. Box 68	Ittending Physician: The law requires that the death certificate be executed death. death. ctor: After this certificate has been signed by the attending physician and it the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	edical Certification; To Be Completed by Physician/Medical	Sequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unknown contributing to the conscious and t	utcome of pregnibirth 2 Feta grant at time of chown death but not result and the properties of Injury anth, Day Year) e of Injury - At high, etc. (Specifical Specifical ence of): ancy al death 3 [leath 5 [sulting in the u BER/Outpatien 28b. Time of Injury ome, farm, str fy) bewledge, death attion and/or inv	DEctopic pregna Other (specify nderlying cause of the second of the seco	26. Place Other: 4 Nu njury at Work? 1 Yes 2 ice e time, date an ny opinion, dea	a of Death oursing Homores	24a. Was an autopsy perform 1 Yes 2 (Check only one 5 Resider and Describe how to the Cathor City or Town, and due to the cathor dat the time, dated	ed? No 24b. \ 24b. \ No 24b. \ 100 ed? No ce 6 \ 100 cet and Numb State) use(s) and male and place, and d. Date signed	nith sibute to the strict of	Pry Day Year The cause of death? The cause of dea	
9	Ittending Physician: The law requires that the death certificate be executed death. death. ctor: After this certificate has been signed by the attending physician and it the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	Medical Certification: To Be Completed by Physician/Medical	Fequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to c. Due to d. 23c. If yes, or 1 Live 4 Preg 9 Unkr ons contributing to Hospital: 28a. Date (Mor gation not be 28e. Plac build and mar or who on lated cau Well keep	utcome of pregnibirth 2 Feta prant at time of chown death but not result of Injury onth, Day Year) e of Injury - At hiding, etc. (Specifical Specifical of): ancy al death 3 [leath 5 [sulting in the u BER/Outpatien 28b. Time of Injury ome, farm, str fy) bewledge, death attion and/or inv	DEctopic pregna Other (specify nderlying cause of the second of the seco	26. Place Other: 4 Nu njury at Work? 1 Yes 2 ice e time, date an ny opinion, dea	a of Death oursing Homores	24a. Was an autopsy perform 1 Yes 2 (Check only one 5 Resider and Describe how to the Cathor City or Town, and due to the cathor dat the time, dated	Mo acco use cont s 2 No 24b.) ed? No ce 6 Oth vinjury occurr use(s) and ma e and place, a d. Date signed	nith sibute to the strict of	Pay Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Lester Edward Mullinix January 12, 2004 9:40p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Hours Days 1**⊠**M 2□F Yrs. 95 **Director** March 10,1908 218-32-0728 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28e-f show tre Medical Experient aust be notified at 1 ☐ Yes 2 X No Director Maryland Howard Mt. Airy 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 1437 Long Corner Road 21771 United States death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ð 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dealer Hay & Straw Sales permit. Pages 1 and 2 should be liled w Department of Health and Mental Hygies Importent: If Item 27 is marked other tt any injury or other treumatic event, ILL 90069. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel E. Mullinix Elsie Moxley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Leon Mullinix/ Brother 1703 South Main Street, Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ⊠Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) Howard Chapel Cemetery 1/17/2004 Mt. Airy, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Sepsis Days /Medical Due to (or as a consequence of); Examiner Days Infuenza Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine inding physician and use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an Atherosclerotic Cardiovascular Disease page 2 s autopsy performed? certificate 2 □ No 1 Yes 2 No 1 Tyes or Attending Physicien: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ⊠npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 TNo 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27, Manner of Death 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending within 24 hours after death.

To the Funerel Director: Af
completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertitier 29c. License number 29d. Date signed (Month, Day, Year) M. 0 D26499 January 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller M.D. # 4 Culwell Drive, Mt. Airy, Maryland 21771 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 2004 Registrar

			1 - For State Registrar	e of Maryland / De		rtment o				giene Reg. No	/ 11111	4 02907
	Physici		1. Decedent's Name (First, Middle, Last) James B. Marshall, J	r.					2. Date of Dea Month January	Da		3. Time of Death 6:51a.m.
}	/Medi Examir		4a. Facility Name (If not institution, give street and Frederick Memorial Ho	number)		4b. City, Tow Fre	m, or Location		January		County of Dec	ath
	Funeral Director		5. Social Security Number 6. Sex 1212-07-2341 12 M 2口	7. Age (In yrs. last birtho	**	If Under 1 Ye Months Da		er 24 Hrs. Min.	8. Date of Birth (Month, Day June 29	h /. Year/	9. Bi 918 Mar	rthplace (State or Foreign Country) Yland
	Maryland -f ahow	tor	Usual Residence of Decedent 10a. State Maryland Tob. County Frederick	10c. City, Town of Adamst								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h with the 23a or 28a at be noti	Funeral Director	10e. Street and Number 3720 Baker Circle			10f. Zip Cod 217				10g. Ci	U.S.A.	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic avant, it a Medical Examinat must be notified at ance.	þ	1 Never Married 2 Married 1 √ Yes	Decedent Ever in U.S. d Forces? es 2 No , Give or Dates:		Vas Decedent Yes, specify C			cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify:	
21215-0036	d within 72 hogiene. In then "netu	Completed	15. Decedent's Education (Specify only highest grade completed in the comp	ed) (C lin	Give k ife. D	ent's Usual Oc and of work do O NOT use re ure Man	ne during mo tired) nufacti	ırers	ative		ind of Business	
Maryland	hould be file d Mental Hy markad othe matic avant,	To Be C	17. Father's Name (First, Middle, Last) James B. Marshall, Sr 19a. Informant's Name/Relationship (Type, Print)		4-111-	414(0)	18. Moti	her's Name la Ado	(First, Middle, l			
e, Ma	and 2 s leaith an m 27 is i		James B. Marshall, III	-son 633	H	arris R	Road, (Charlo	-	lle,	Virgir	<i>Zip Code)</i> nia 22902
altimore,	t. Pages 1 tment of H tant: If ita		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. Place of Di cemetery, Frederi	crem	atory or other i	place)	□ 19/2/	-		erick,	Town, State Maryland
Ba	Depar Impo any ir		21. Signature of Funeral Service Librasee		16		sumtov	vn Pik		leri		ome cyland 21702
) *	Physician /Medical Examiner	ner	Sequentially flat our filtuna	at caused the death. Do not on each line. ETABCLIC AX to (or as a consequence of): VERTICULAR to (or as a consequence of):	CIL	0515		s cardiac o	respiratory arm	est,		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and of for use as the burial-transit	edical Examiner	that initiated events	to (or as a consequence of):	:							
.O. Box	the death certifica yy the attending pt ached for use as ti	Physician/Medical	in the past 12 months?			Ectopic pregnal Other (specify)				4	23d. Date of del Month	livery Day Year
ecords, P.	law requires that the de as been signed by the a 2 should be detached t	þ	Part II. Other significant conditions contributing t	o death but not resulting in th	e und	derlying cause	given in Part	l,	23e. Did tob			the cause of death?
r	The ate h page	Completed							24a. Was as autops perform	У	prior to death?	utopsy findings available completion of cause of
	ng Phys fter this neral di	atlon; To Be	25. Was case referred to medical examiner? 1	Inpatient 2 ER/Outpat ate of Injury Injury Injury	e of	28c. In	Other: 4 🗆 N	ursing Hom	(Check only of one only of one only of one only of one only one one one one one one one one one one	nce 6		cify)
Division	he Mospital or Attending n 24 hours after death, he Funeral Director: After oletely filled in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, farm, ilding, etc. (Specify)	, stree	at, factory, office	20	2	8f. Location (Str City or Town	reet and , State)	d Number or Ru	ıral Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the	ledical		the best of my knowledge, de e basis of examination and/or anner stated.	eath o	occurred at the stigation, in my	time, date ar y opinion, dea	nd place, ar ath occurred	nd due to the ca	use(s) ite and	and manner as place, and due	stated. to the cause(s)
,		Ž	29b. Signature and title of certifier				0 251	51	29	d. Date	signed (Mont)	h, Dey, Year)
	l;		30. Name and address of person who completed a Gerald Winnan,	M.D 310	pe, Pr	N. 9+	hSt	Free	tenck,	M	D21	701
fy.	Star Registra	te ar	31. Date filed (Month, Day, Year) 32 JAN 2 0 200	. Registrar's Signature		6	boare	21				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month DONNA JANUARY SUE MARKUSKI 21 /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick
If Under 1 Year | If Under 24 Hrs. Frederick 5. Social Security Number 9. Birthplace (State or Foreign Country) South Dakota **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, August 31 Hours Months Days 1 □ M 2**X**()XF 50 220-58-3274 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2XXVo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 9207 Bloomfield Road 21702 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes & XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White þ 3 Widowed X Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Dental Assistant Dental Care 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Earl W. Todd Dorothy Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any njury or other trau Tiffany Markuski/ Daughter 10301 Huron Court/New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory, Inc. Jan. 23,2004 Frederick, Maryland 21. Signature of Funeral Service I 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only specialise on each line. 1621 Opossumtown Pike/Frederick, Maryland 21702 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIC **Physician** DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed **burial-transit** Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical the as 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 TlUnknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed; 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Maturai within 24 hours after death. To the Funeral Director: A 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 1)26499 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Culwell Drive Mt. Airy, MD 21771 Dr. Ronald Miller 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 02909 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Yeer Deborah Lynn Nelson-Harless January14,2004 /Medical 8:15A 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 1 ☐ M 2 ☐ F 47 Director 215-66-9859 July 23, 1956 Maryland Usual Residence of Decedent Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 17 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Medical Examinar must be notified at Maryland Frederick Director 1 ☐ Yes 2 No Frederick the 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? death with 5805 Whitfield Court 21703 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Deportment of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural," or item any njury or other traumatic event, the Medical Evented Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Records Technician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William E. Nelson Joan Kuster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Harless - husband 5805 Whitfield Court, Frederick, Maryland 21703 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Memorial 1/19/2004 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signatur of Funerat Service Licensee Karon 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 30 m mular /Medical Due to (or as a consequence of) Examiner Mysecodial Infaction 1006 25 Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to log as a consequence of): Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month 4☐ Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 TYAS 2 No. 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No a Sec autopsy tobaco Division of Vital 1 Yes 2 No Be 25. Was care referred to medical exampler?
1 Yes 2 No 26. Place of Death Check on one) Hospital: 1 Inpatient Other: Certification: To 2 PER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Vatural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director; completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide tip Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of ceptified 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) Gail T. Griffin 400 W. Seventh Street, Frederick, Maryland 31. Date fited (Month, Day, Year) 32. Registran's Signature oaks) JAN 2 0 2004 > Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 14,2004 9:00p January Howard Courtney Nicodemus /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3138 Upland Ridge Drive Adamstown Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 12 M 2 ☐ F Yrs 86 30,1917 New York Director 219-03-4346 Dec. Usual Residence of Decedent a filed within 72 hours after death with the Maryland at Hygiene. other then "natural", or Itams 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itams 23a or 28a-f show edical Examinations be notified at 1 ☐ Yes 2X No Directo Maryland Frederick Adamstown 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number <u>United S</u>tates 21710 3138 Upland Ridge Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Right of way Agent Baltimore City permit. Pagas 1 and 2 should be file Cepartment of Haalth and Mental Hy Important: If Item 27 Ie markad oth any injury or other traumatic event genee. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gordon Nicodemus Elizabeth Mary Staley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3138 Upland Ridge Drive, Adamstown, Maryland 21710 Mary Charlotte Nicodemus/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1/19/2004 1 図Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. Michaels Church Cemetery Mt. Airy, Maryland 21. Signature of Fundal Service Licenses 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY Physician 5 Des JHNWHILENLE /Medical Due to (or as a consequence of): Examiner 10 Doy PREUMOMA Sequentially list conditions, lary, leading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be axecuted attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) , the & 9 Unknown 9 Unknown signad by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 10 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 Yes 2 1 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Yes 2 No ို this After thi funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: , filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of o 7-31912 120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1464 OPOSTUMZULA PIUE, THED ENICH, MA MEMORINE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 20,2004 GOLDA MAE PRESTON 12:30 P.M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Nursing Home Frostburg If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. 8. (Mon Allegany 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 XF Months Yrs. 215-18-8379 March 07, 1921 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19708 Thomas Hill Road 21532 USA 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Post Master Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elijah H. Smiley Edna Thrasher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Thompson-Daughter 19708 Thomas Hill Road, Frostburg, Md. 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State January 23, 4 ☐ Donation 5 ☐ Other (Specify) Rest Lawn Memorial Gardens 2004 LaVale, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 E. Main 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST CARCINOMA Aou 134 ps Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. DId tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⊋ Unknown SAN CYTOPEN A 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CHRUNIC OBSTRUCTIVE LUNC DISTERNE 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 No

Physician /Medical Examiner Examiner

attending physician and I for use as the burial-transit

sate has been signed by the a page 2 should be detached

certificate

: After this certifica e funeral director, p

To the Hospital or Attending within 24 hours after death.

'To the Funeral Director: Afte completely filled in by the fun

or Attending Physicien:

Physiclan/Medical

Completed by

Be

Certification: To

Medical

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Physician

Examiner

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, I'm Medical Examinat mast be notified at

Baltimore, Maryland 21215-0020

/Medical

Director

Funeral

\$

Completed

Be P 10a. State

Sequentially list conditions, if any, leading to immediate cause. Enter third trying Cause (Disease or injury that initiated events resulting in death) Last

1 ☐ Yes

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

(Check only

29b. Signature and title of certifier

5 ☐ Residence	6 ☐Other (Specify

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

HFrollin

126907

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be determined

Bishes 925 32 Registrar's Signature

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

WALSh Road Cumberland, MD. 21502

28c. Injury at Work?

1 Yes 2 No

Mas State

Registrar

			. For	use (Mental Hy		-	
			1 - State Registrar				Ce	rtificate of	Death	1	Reg. No	200	4 029 2
М	Dhysisi		1. Decedent's Name (First, Mic	die, Last,)					2. Date of Dea	ath Da	y Yea	3, Time of Death
	Physici /Medic		David		Thoma	a s		Prysock		JANUARY			M
	Examir	er	4a. Facility Name (If not institut	ion, give	street and numbe	er)		4b. City, Town,	or Location of Dea	th	40	. County of De	
	* * * * * * * * * * * * * * * * * * *	ш	MEMORIAL HOSPI	_				CUMBERL				LEGANY	
	Funeral		5. Social Security Number	6. Se:	x 7.7 ŠM 2□F	Age (In yrs. 64	last birthday) Yrs.	If Under 1 Year Months Days		. (Month, Da	h y, Year)	9. B	irthplace (State or Foreign Country)
8.4	Director		232-60-5709 Usual Residence of Decedent			04				05/28/1	939	Wes	st Virginia
	/land		10a. State 10b. Coun	ty		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Man Fied	to	WV M:	inera	a I	R	idgeley	Ţ					1 ☐ Yes 2XXNo
	or 28	Director	10e. Street and Number					10f. Zip Code			10g. Cit	izen of What 0	Country?
	death with the Maryland me 23e or 28e-f ehow L'istal Le notified at	aD	Route 2 Box 3	366 (Parker 1	Road)		2675	53			USA	
	dea T	Funeral	11. Marital Status		12. Was Deceder Armed Force	nt Ever in U	J.S. 13.	Was Decedent of I	Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)		14. Race - An Black, Wh	nerican Indian,
9	or it	y Fu	1 ☐ Never Married 2 ☑ M		1 ☐ Yes 2X If Yes, Give	χνο		1 ☐ Yes 2 🛣 No		to riloan, otc.)		Specify:	iite, etc.
21215-0036	72 hours after death with the Marylar natural; or iteme 23e or 28a-f show iscal Examiliad at	d by	3 Widowed 4 Divorce		Year or Dates	s:							White
င်	n 72	Completed	15. Deced (Specify only high	ent's Edu est grad	cation e <i>completed)</i>		16a. Deced	lent's Usual Occu kind of work done DO NOT use retire	pation during most of wo	orking	16b. K	ind of Busines	s/Industry
2	within 72 ane. than na	mc	Elementary/Secondary (0-12 1 2)	College (1-4o	r 5+)	me.	Superint			,	2	
2	filed Hygi other	ပ္သ	17. Father's Name (First, Middle	e, Last)				Superint		me (First, Middle,		Sumame)	
a	9 E E E	To Be	Ross		D	1.							C
Maryland	should not marke	-	19a. Informant's Name/Relation	nship (Ty		rsock	19b. Mailir	ng Address (Street	Ida and Number or R	Ann ural Route Numbe			fe Zin Code)
	and 2 Balth a n 27 io		Lois J. Prysoc	k /	wife					eley, WV		5753	2.5 0000)
Baitimore,	- 호 등 등		20a. Method of Disposition				Place of Dispo	sition (Name of natory or other pla		Date		ocation - City o	r Town, State
Ê	permit. Pages Department of Important: If it any injury or o		1 ☐ Burial 2 ☒ Cremation 1 ☐ Donation 5 ☐ Other		lemoval from Stat	.0							10 1940cm
	mit.		21. Signature of Funeral Service		997)	Cur	nberlar 22	. Name and Addre	ory 01/2	dams Fam	ilv	herlan Funera	1 Home, P.A.
ñ	Depa impo any i		tabent (-6	Ellerna			404 Deca	tur Stre	et, Cumb	erla	and. MD	21502
			23a. Part1. Enter the disease, shock, or heart failure. Li	or compli	ications that cause	ed the deat	h. Do not ent						Approximate
9	Physician		Immediate Cause (Final disease or condition	st offiny of			דוד יישי	ለሮ ለውጥፑው	Y ANEURY	2M			Onset and Death
	/Medical		resulting in death)		Due to (or a			AC ARIER	I ANEOKI	311			36 HOURS
	Examiner	П	Conversion to the conditions	1.	ATHEROS	CLERO	SIS						20 YEARS
	ס ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	"	Due to (or a								
	be executed ician and burial-transit	Examiner	that initiated events										
/bg/	e exe sian a urial-		resulting in death) Last		Due to (or a	is a conseq	uence of):						
	5 S 6	lcal			i								
X DX	certificat nding phy use as th	Physician/Med	IF FEMALE:		0. 16						- 1		
X D	death c	lan/	23b. Was decedent pregnant in the past 12 months?	2	3c. If yes, outcom 1☐Live birth	2 Feta	I death 3	Ectopic pregnanc	у		11/11:	23d. Date of de Month	elivery Day Year
o.	the s	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant 9□Unknown	at time of d	eath 5∟	Other (specify) _					ouy rour
7.	that the		Part II. Other significant condi	tions con	tributing to death	but not res	ulting in the ur	derlying cause on	ven in Part I	23e Did to	hacco u	se contribute t	to the cause of death?
g	The law requires that the site has been signed by the bage 2 should be detached.	d by	ABDOMINAL AOR					,g oacoo g	on are ditti.				robably 4 Unknown
ecords	v requ been shoul	ete	ADDOMENAL AON	110	ANEUKIDE								
ĕ	G 55 CA	Completed								24a. Was a autops	sy	24b. Were a prior to death?	utopsy findings available completion of cause of
	n: Th										2 No	1 🗆 Ye	s 2 No
N N	sicien: The law s certificete has t irector, page 2 s	o Be	25. Was case referred to medic examiner?	1.00	lospital: 📈			3 DOA Oth		ath (Check only on			
5	Phy r this aral d	\vdash	1 ☐ Yes 2 No 27. Manner of Death		28a. Date of In		ER/Outpatien	3000	4 Li Nutsing F	lome 5 Reside			ecify)
VISION	th. Th. Afte	ţ	1 Natural 5 Pend 2 Accident inves	ling tigation	(Month, D	ay Year)	Injury	28c. Injur Wor M 1	rk?` Yes 2 ∐No	200. 0000100 110	ow mijar	y occurred	
<u> </u>	Atter dea octor by the	ifica	3 ☐ Suicide 6 ☐ Coul	-	28e. Place of Ir	njury - At ho	ome, farm, stre	et, factory, office		28f. Location (St	reet an	d Number or R	tural Route Number,
5	after after din b	Certification;	4 Homicide		building, e	etc. (Specifi	y)	,,		City or Town	n, State,)	
	pspit hours unera y fille		29a. Certifier 1 Certify	ing Phys	ician: To the bes	t of my kno	wledge, death	occurred at the tir	me, date and place	, and due to the ca	ause(s)	and manner a	s stated.
	To the Hospitel or Attending Physicien: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medica one)	i Examir	and manner s	of examina	tion and/or inv	estigation, in my o	pinion, death occu	irred at the time, d	ate and	place, and du	e to the cause(s)
	To Twith	Σ	29b. Signature and title of certif	ier	C1 17		6.0	29c. Licens		2	9d. Dat	e signed (Mon.	th, Day, Year)
	4/1		Kan	リ.	1-11/1/	1	MD,	1.	134362		1	121/04	t
(211		30. Name and address of rso	n who co	mpleted cause of	death (Item	23a) (Type, f	Print)					
_	h LS		ROY D. CHISHOL	<u>M, M</u>	.D., 924	SETO	N DRIV	E, CUMBEI	RLAND, MA	ARYLAND 2	150	2	
	Stat Registra		31. Date filed (Month, Day, Yea JAN 2			trar's Signa	ture	Loan	1				
		1	UMIYA	W LU	UTI		for	11.69 J 682 A	1				

		1 - For State Registrar	State of Maryla		artment of I			giene Reg. No.	2004	02913
Physic	ian	Decedent's Name (First, Middle, Last Winifred	J u ne		Duby		2. Date of De Month	Day	Year	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, give			Ruby	or Location of	JANUAI Death		2004 ounty of Death	21:57 ™
E Xaiiiii	ici	MEMORIAL HOSPITAL	,		CUMBERLA				LEGANY	
Funeral		Social Security Number 6. Se	X	. last birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of Bir Min. (Month, Da	th	9. Birthp	lace (State or Foreign
Director		210-10-2914	⊐м 2⊠ғ 79	Yrs.	Months Days	Hours	05/30/	1924	Mary	
and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity. Town or Lo	cation				1	0d. Inside City Limits
f sho	ō	MD Allega		Flintst						1 ☐ Yes 2 ☐ No
28a	Director	10e. Street and Number	iry	TIMESE	10f. Zip Code			10a, Citize	on of What Cour	ntry?
death with the Maryland ms 23a or 28a-1 show Invelor rectified at	i D	21706 National Pi	ke. N.E.		215	30		USA		,
	Funerai	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13.			n? (Specify Yes or No Puerto Rican, etc.)		. Race - Ameno	
or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2X No		1 ☐ Yes 2Ã No		Puerto Filcari, etc.)		Black, White,	etc.
hours at the control of the control	d by	3 Widowed 4 XDivorced	Year or Dates:						Wh	ite
n 72 n 72	Completed	15. Decedent's Edu (Specify only highest grad	ication le <i>completed)</i>	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	of working	16b. Kind	of Business/Ind	dustry
with in the result of the resu	EO	Elementary/Secondary (0-12) 12	College (1-4or 5+)		Homemake	,		Hom	emaker	
III 4 12 13-0050 be filed within 72 hours after tal hygiene, d other than "naturel; or ite event, tra Medical Examina	BeC	17. Father's Name (First, Middle, Last)					s Name (First, Middle,			
vild be file	TO E	Dayton	Dexter	Do 11	y	Verda	a Ma	arie	A	1t
and Men sand Men sand Men sand marke summatic		19a. Informant's Name/Relationship (T)	·				or Rural Route Numbe		own, State, Zip	Code)
and and ealth m 27	- S	D. Allen Ruby, Sr.			-		stone, Mar	y land	21530	
Deficilitions, Mary is permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	TOTO VALUE OF THE STATE		sition (Name of matory or other pla		Date	20c. Loca	tion - City or To	wn, State
Deficiency Permit. Pages Department of Importent: If it Iny injury or or		*4 □Donation 5 □Other (Specify)			Cemetery				tstone,	
Dermi permi Departimon Impo		21. Signature 1 Funeral Service Licens	Police of	22			Adams Fam: Street, Cur	-		•
		23a. Part1. Enter the disease, or compl	ications that caused the dea	th. Do not ent					anu, no	21502 Approximate
Physician /Medical Examiner (cate be executed (cate be executed (cate be niver transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	quence of).	PHEV	MON	IA			Onset and Death Conset and Death
The Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 又 No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	el death 3 □	Ectopic pregnancy	y		230	d. Date of delive Month	ry Day Year
w requires that s been signed E should be detailed.	leted by PI	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the ur	nderlying cause giv	ven in Part I.		obacco use		e cause of death?
as be	ple						24a. Was		24b. Were autop	sy findings available
The ate h	Compl							med?	death?	pletion of cause of
cian: ertific	Be (25. Was case referred to medical examiner?				26. Place of	f Death (Check only or			
hysle this c	၉	1 ☐ Yes 2 💢 No	lospital: 1 🕱 Inpatient 2		The second second	4 Nurs	ing Home 5 🗆 Resid	lence 6	Other (Specify)
ling F	ion	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe h	iow injury o	ccurred	
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Attent his certificate has completely filled in by the funeral director, page 2.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre		Yes 2 ☐ No	28f. Location (S City or Tow		lumber or Rural	Route Number,
the Hospit in 24 hours the Funera	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best of my kniner: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the tinestigation, in my o	me, date and popinion, death	place, and due to the doccurred at the time, o	cause(s) an	d manner as sta ace, and due to	ited. the cause(s)
To 1 To 1	Σ	29b. Signature and title of certifier	O A		29c. Licens	e number			igned (Month, D	
/		Moleustramo	1. 18am	hey V	D148	865		JAN.	22-	2004
711		30. Name and address of person who co								
1100		BARRERA, ROBUSTIAN 31. Date filed (Month, Day, Year)	O. J., M.D., 5		URIAL AVI	ENUE, S	SUITE 201,	CUMBI	ERLAND,	MD 21502
Sta Registr	_	JAN 2 2 201	1/ Negistrar's Signi		Anna k	11				

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January20, 2004 6:55A Russell Sirk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. Director 217-12-1748 82 April 1,1921 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits s 23a or 28a-f show oust be notified at 1 ☐ Yes 2 No Maryland Carrol1 Mt. Airy Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3915 Twin Arch Road 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner or 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 DXYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Printer Box Factory other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fil tment of Health and Mental H rtant: If item 27 is marked ott tjury or other traumatic ever Be ပ William Sirk Sarah Delauter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ertment of Health are curtant: If item 27 is injury or other trau Jane S. Baker/ Daughter 7926 Dogwood Drive, Mt. Airy, Maryland 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery 1/24/2004 Mt. Airy, Maryland permit.
Deporte
Importe
any inju 21. Signature of Enneral Service 02. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home pode 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Myo condied Injovetion Minutes /Medical resulting in death) Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events meumenia Due to or as a consequence of) Examiner death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, he attending physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year P.O. F 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 Tes 2 No rector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 x Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No funeral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide ō within 24 hours a

To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D43091 1-22-04 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Tole House Are, Brekenn, pm MM 801 SAEED PAINI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 3 20 JAN Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JAN. 16 2004 LILLIE CATHERINE THOMAS 10:11am /Medical 4b. City, Town, or Locetion of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Funeral. Months Days Count VA 1 ■ M 2 D F Yrs. SEPT 85 1918 227-46-5204 Director Usuel Residence of Decedent Permit. Peges 1 end 2 should be filed within 72 hours effer death with the Merylend Department of Heelth end Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits, 10a. State 10b. County 1 ☐ Yes 2 ☑ No MD MONTGOMERY DICKERSON Funeral Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 2422 RIVER ROAD 20842 Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status 1 □ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NANIE INAS ROCK SAMUEL CLINTON THOMAS 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JAMES WILSON / FRIEND 24434 RIVER RD., DICKERSON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/17 FREDERICK CREMATORY FREDERICK, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical a Cardiac second s **Examiner** Due to (or es a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed efter death.

Director: Atter this certificate hes been signed by the ettending physician end Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): use es the 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Medical Certification: To Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Deeth 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a Certifier

Division of Vital Records, P.O. Box 68760, completely filled in by the funerel To the Hospital within 24 hours e To the Funeral D

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end titte of certifier JANUARY 16, 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DAVID KLEIN, 9901 MEDICAL CENTER DR., ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year)

State Registrar

32. Registrer's Signeture

JAN 2 0 2004

2004

v		1 - For State Registrar		ryland / Depa	artment of Health ar rtificate of Death	nd Mental Hyg	_	02917
		1. Decedent's Name (First, Middle,	Last)			2. Date of Deat		3. Time of Death
Physici /Medio		Lillian G	eneva Trave	rs		January	fe 2004	5:35 ам
Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, or Location of I	Death	4c. County of Death	
		Dorchester Ge	neral Hospi	tal	Cambridge		Dorches	ter
Funeral Director		214-12-6562	Sex 7. Age 1 M 2 S⊈F	(In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of Birth (Month, Day, Oct. 14	Year) 9. Birth Cour , 1921 Ma	place (State or Foreign ntry) ryland
and w		Usual Residence of Decedent 10a. State 10b. County	T	10c. City, Town or Lo	ocation		1.	Od. Inside City Limits
danyh f sho	ក	MD Dorch	ester		Cambridge			1 Yes 2 □ No
1 28 th	5	10e, Street and Number			10f. Zip Code	10	ng. Citizen of What Cou	ntry?
3a or		525 Glenburn A	venue		21613		U.S.A.	•
death ms 2	Jera	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No-	14. Race - Americ	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be mailied at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		if Yes, specify Cuban, Mexican, F 1 ☐ Yes 2 ☑ No <i>Specify:</i>	rueno Hican, etc.)	Black, White,	etc. ite
2 ho	ted	15. Decedent's	Education	16a. Deced	dent's Usual Occupation	funding	6b. Kind of Business/In	dustry
thin 7	ple	(Specify only highest (Elementary/Secondary (0-12)	College (1-4or 5+	.)	kind of work done during most of DO NOT use retired)	WOIKING		
D D D D D D D D D D D D D D D D D D D	Son	11			bookkeeper		state gove	rnment
at Hy at Hy	Be (17. Father's Name (First, Middle, La				Name (First, Middle, N	faiden Sumame)	
Ment Ment	2	Axel Rudolf F	eterson		Este	er Clausen		
and and is mu		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street and Number of	or Rural Route Number,	City or Town, State, Zip	Code)
and and n 27		Mary Lou Heintze	lman daughte		Bell Lane, Woo		21677	
or High		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3	□Removal from State	20b. Place of Dispo cemetery, crer	esition (Name of matory or other place)	Date 2	20c. Location - City or To	own, State
mit. Pages partment of portant: If it y injury or c		'4 □Donation 5 □ Other (Spe		Dorcheste	er Memorial Park	1/16/04	Cambridge,	MD
mit.		21. Signatur of Funeral Service Lic	ensee	22	2. Name and Address of Facility	Thomas Fu	neral Home	P.A.
0 82558		John W le	Lake.	7	00 Locust St.,	Cambridge,	MD 21613	
Pnysician		23a. Part / Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	emplications that caused to try one cause on each line	PNEU W		rdiac or respiratory arre	st,	Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	Your a			5 22495
Examiner								
	Jer	if any, leading to immediate	Due to (or as a	consequence of):				
ate be executed aysician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events	С.					
e exe	Ë	resulting in death) Last	Due to (or as a	consequence of):				
ate be ex sysician he buria	cal		d.					
ng ph	Ned	IF FEMALE:						-
w requires that the death certifica vequires that the death certifica been signed by the attending phe should be detached for use as the	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome o		Ectopic pregnancy		23d. Date of delive	,
s dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at ti 9□ Unknown		Other (specify)		Month	Day Year
at the lby the stach	hy	9 Unknown						
es th igned	by	Part II. Other significant conditions					acco use contribute to th	
requir een s nould	ted	O Gane	Porah	synaro	ne	1 _ Ye:	s 21√No 3 ☐ Prob	ably 4 ∐Unknown
law r as be	Completed	V				24a. Was an autopsy		psy findings available inpletion of cause of
The The ate h)ou					perform 1 ☐ Yes 2	ed? death?	2 No
sian: sartific ctor,	Be (25. Was case referred to medical examiner?				Death (Check only one		
ding Physician: The lav ding Physician: The lav h. After this certificate has funeral director, page 2	2	1 ☐ Yes 2 → No	Hospital: 1 Impatien	The state of the s	t 3 DOA Other: 4 Nursi	ng Home 5 🗆 Resider	nce 6 Other (Specify	")
ng Pl	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a, Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how		
tendi death. tor: A the fu	ati	2 Accident investigat			M 1 ☐ Yes 2 ☐ No			
r Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, farm, str (Specify)	eet, factory, office	28f. Location (Streetly or Town,	eet and Number or Rura State)	l Route Number,
ris af						N.		
Hosp 4 hou Fune ely fil	edical	(Check only 2' Medicel Ex	aminer: On the basis of e	examination and/or inv	n occurred at the time, date and p vestigation, in my opinion, death of	lace, and due to the car occurred at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
Livision of vital neconics, FC. BOX 0917 in the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the formal or the funeral director.	Med	one)	and manner state	ed.				
To Will	-	290. Signature and title of certifier	Ahow Mi)	2ac. License number	29	a. Date signed (Month, l	vay, rear)
		Jau	U		09172	7	, , , , , ,	
		30. Name and address of person wh	o completed cause of de	ath (Item 23a) (Type,	Print)	AMPDIA.	MO.	2/6/2
		31 Date filed (Month Day Vocal	J-W- J JU	- NUROF	- JACEY	V. MAIDE	e .	-13
Sta Registr	te ar	29b. Signature and title of certifier 30. Name and address of person wh NOMAN TITLE 31. Date filed (Month, Day, Year)	1 2 1 200491stran	Besser D	a special			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amended#10a perFH FCHD KS Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 8:10 P M STEPHEN WALTERS JANUARY 9 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months 1⊠M 2□ F 228-62-8534 57 17, 1946 California Usual Residence of Decedent 10b. County 10c. City. Town or Location. 10d. Inside City Limits Virginia 1 ☑ Yes 2 ☐ No Maryland Fairfax Arlington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6230 Arlington Blvd. #202 22044 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No Viet If Yes, Give Year or Dates: Nam 1 Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Nam 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Statistition U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leonard Walters Jο 0slin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Walters / brother 42 Meyersville Road Chatham, N.J. 07928 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Frederick Cremetory 1/13/2004 Frederick, Maryland 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Stauffer Funeral Homes P.A. 1621 Opossumtown Pike Frederick, MAryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition neumonia - WILL resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of). 23c. If ves. outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

and

attending physician a l for use as the burial-

signed by the a

Deen

has s certificate has lirector, page 2

this

After

the

yd ni

death.

within 24 hours after death To the Funeral Director:

The law requires that the death certificate be executed

Box 68760,

P.O. I

Division of Vital Records,

or Attending Physicien:

Hospital

To the

Physician

Examiner

Funeral

Director

item 27 is marked other than "netural", or itame 23a or 28a-f show other traumatic event, the Medical Exeminar mass by notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than 'any injury or other traumatic event, the Meones.

Funerai

à

Be

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

10a. State

Examiner Physician/Medical à Completed Be 2 Medical Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 25. Was case referred to medical examiner?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 1 No 1 🗌 Yes 24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3 ☐ Probably 4 ☐ Unknown

2**X** No 26. Place of Death (Check only one)

1 Yes &Z No 27. Manner of "eat 1 Natural 2 Accident 5 Pending

3 Suicide

29a. Certifie

4 - Homicide

28a. Date of Injury (Month, Day Year) investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13.D

B5-C

D00604

Hemen SHAH 31. Date filed (Month, Day, Year)

JAN 2 2004

32. Registrar's Signature

Dr. Frederick MD-21702

State Registrar

21

			1- For State Registrar Amended#8pe	State of Mar			of Healt			giene 30g. No. 200	L 02919
	Bhysia	ion	1. Decedent's Name (First, Middle, Las						2. Date of Dea Month		3. Time of Death
	Physic /Medi			Myrtle	Wilse					y14,2004	7:35P M
	Examir	ner	4a. Fecility Name (If not institution, give				own, or Locat	tion of Death		4c. County of De	
	-		Frederick Memori 5. Social Security Number 6. Se		(In yrs. last birthday)	Fred If Under	erick Year lf Ur	nder 24 Hrs.	8 Date of Birth	Frederic	
н	Funeral Director			□ M 2⊠F	71 Yrs.	Months			8. Date of Birth (Month, Day Sept. 6		Birthplace (State or Foreign Country) roinia
	D		Usual Residence of Decedent							oer 6,1932	
	arylar ehow	<u>_</u>	10a. State 10b. County		Oc. City, Town or Lo						10d. Inside City Limits
	the M	ecto	Maryland Frederick 10e. Street and Number		Frederick					0.00	1 □XYes 2 □ No
	with a or	Funeral Directo		Desire		10f. Zip (10g. Citizen of What	,
	death	era	212 Heather Ridge	12. Was Decedent Eve	er in U.S. 13.1			Origin? (Spe	ecify Yes or No-	United St	aces
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f ehow eny injury or other traumatic event, If a Medical Exactinal must be notified at 2008.		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		f Yes, speci 1 ☐ Yes 2			ecify Yes or No- Rican, etc.)	Black, Wi	
5-0	72 ho	Completed by	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece	dent's Usual	Occupation done during	most of works		16b. Kind of Busines	
7	within 900 than 100 Med	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)	most of work	ing		
12	filed with Hygiene. Ather ther		6		Nurse	's Ai				lealthcare	Field
Maryland	d be find the of of ot	Be	17. Father's Name (First, Middle, Last) James Emmett	ጥኤ ‹	orpe			lothers Name rdie	_	Maiden Surname)	 -
2	2 should be f and Mental H is marked of sumatic ever	10	19a. Informant's Name/Relationship (T			a Address /			Lavett	r, City or Town, State	nery
	and 2: saith ar n 27 is			rother			Smith			Maryland	
Je,	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition		20b. Place of Dispo cemetery, crem				-	20c. Location - City	
E	Pages nent of I int: If it		1 🖾 Burial 2 ☐ Cremation 3 ☐ i 4 ☐ Donation 5 ☐ Other (Specify,	Heinovar nom State	Resthaven			1/20/	/2004 F	rederick,	Maryland
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens							ineral Hom	
_	20E 2 9		N.B.G.	rise							aryland 2170
ı			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused then cause on each line.	e death. Do not ent				1	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Chemit	065th	dir	PVI	mine	ry 1)	15-eas-e	Onset and Death
e 動作	/Medical Examiner		rosuming in occurry	Due to (or as a c	consequence of):				1		/
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	onsequence of):	_					
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	an an rial-tr	Exa	resulting in death) Last	Due to (or as a c	onsequence of):						
8760,	ate be hysici	ical		d							
9	entifica ing pl	Med	IF FEMALE:								
). Box	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pred Other (spec				23d. Date of d Month	elivery Day Year
P.0	fhat the d ed by fhe defached	Phy	9 Unknown		and annual line in the con-	4			00. 014		
ords,	law requires that the as been signed by th 2 should be defache	ted by	Part II. Other significant conditions co	ninbuing to death but h	not resulting in the ur	ogerlying cat	ise given in Pa	ап I.	239. Did tot		to the cause of death? Probably 4 □Unknown
Vital Records,	The afe h page	Completed							24a. Was a autops perform	y prior to ned? death?	autopsy findings available completion of cause of
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					lace of Death	(Check only on	θ)	
of	Phys this al dii	2	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient		_			nce 6 Other (Sp	ecify)
on	ing After une	Certification:	1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	M 280	i. Injury at Work? 1 ☐ Yes 2		28d. Describe ho	w injury occurred	
Division	De de de de de de de de de de de de de de	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, stre				28f. Location (St.	reet and Number or F	Rural Boute Number
Ö	al or affer t Dire	erti	4 Homicide	building, etc. (Specify)	, , , , , , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	City or Town	, State)	rarar rioute rearriber.
	To the Hospital or Attu- within 24 hours affer de To the Funeral Direct completely filled in by the	edical (29a. Certifier (Check only one) Certifying Phy	sician: To the best of maner: On the basis of example and manner stated	amination and/or inv	occurred at estigation, in	the time, date my opinion, o	and place, a death occurre	and due to the ca ed at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	1			icense numb		25	9d. Date signed (Mon	th. Day, Year)
,			* / Hew !!	Em s			0031	OFD		1/16/0	Ý
	2		30. Name and address of person who co	mpleted cause of death	h (Item 23a) (Type, f	Print)	11	1 /	/	À	12
	- 01	to	31. Date filed (Month, Day, Year)	0 2 t 0 32. Registrar's	Signature	nial	NY G	100114	sin n	11) 2129	Y
	Sta Registr	2.0	JAN 2 0 2		wa b	1_1	bouts	1		1) 2129	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item/ PerFHG828 2/21/04 EW Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1842 M 2004 JAN ThomAS Williams /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HAYERSTOUR OUNT ShINGTON ASHINGTON 405p, +A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth2/8/1912 9. Birthplece (State or Foreign Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 214-09-020 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28e-f shov treumatic event, If a Medical Examiner must be notified at 1 Yes 2 No ns) tagERSTOWN Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S 1305 or Items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after a ment of Health and Mental Hygiene. The filem 27 is marked other than "natural, or flee ury or other treumatic event, IT a Madical Estation ury 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) DERVISOR 18. Mother's Name (Firşt, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ORTER Kussell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1305 CEDAR WOOD DR HAGERSTOWNAD. WILLIAMS JEORGIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-19-04 HAGERSTOUN permit. Page Department of Importent: If any injury or ST HAVEN CENV * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Faciling ARUL. ROLLING FUNCERAL IT ONE 21. Signature of Funeral Service Dicensee 16 ST. FRED. MO. 23a. Part1. Enter Me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myolahel Interction Physician /Medical Due to (or as a consequence of): Examiner >~ respectionis Sequentially list conditions, if any, leading to immediate the Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examlner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as the IF FEMALE Box esn n 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ò in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Hunkñown erule. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Chronic autopsy performed? Yes 2 2 N has 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one)

of Vital To the Hospitel or Attending Physicien: Division death. in by the Director: within 24 hours after d

To the Funerel Direct
completely filled in by

Be 2

27. Manner of Death Certification: Medical

29a. Certifier

1 Yes 2 → No

1 Alagural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

4 Homicide 1[Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

1220 MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient

28b. Time of

3 DOA

D(8019

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) JAN 15, 2004

MD 21740

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

MAKERSTOWN

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILL ST

NYYAG VASANT MD 340

State Registrar

3

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 0 2004

1 Inpatient

28a. Date of Injury (Month, Day Year)

			_ For	State of Marylan	id / Department of H	ealth and Mental	Hygiene 200	
			1 - State Registrar		Certificate of L		Reg. No. 200	4 02322
10	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last August 1	Aquino	4b. City, Town, or	2. Date Monti	. 700 0001	11.35AM
en land	Funeral Director		216-01-5376	EM 20 F 7. Age (In yrs.	last birthday) If Under 1 Year Months Days	KIVK If Under 24 Hrs. 8. Date Hours Min. (Mont May	of Birth th, Day, Year) 9. B 30 1912 M	NORD irthplace (State or Foreign Country) URY/UNA
	ne Maryland 8a-f ehow diffied at	ector	Usual Residence of Decedent 10a. State 10b. County AD Balty	nore Ro	ry, Town or Location Sedüle			10d. Inside City Limits
	d within 72 hours after death with the Maryland liene. rithen "netural", or items 23a or 28a-1 ehow the Medical Ezenerect qual be rediffed at	Funeral Director	10e. Street and Number 1917 Underlie 11. Marital Status	12. Was Decedent Ever in U	S. 13. Was Decedent of Hill If Yes, specify Cuba	3.7 ispanic Origin? (Specify Yes in, Mexican, Puerto Rican, etc	or No- c.) 10g, Citizen of What C	nencan Indian,
5-0036	72 hours after natural', or ite	by	1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 15. Decedent's Ec (Specify only highest gra		1 ☐ Yes 2 🗖 No	Specify:	Specify: W	hite
2121	othe othe	e Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	auto MICH	18. Mother's Name (First, M	auto R	epair
Maryland	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	ToB	NOMINICK A	SULIO T po, Print)	19b. Mailing Address (Street a	MARY A and Number or Ru al Rou N	SSINS Number, City or Town, State	Zip Code) 2/237
Baltimore,	Page ment o ant: If ury or		20a. Method of Disposition DE Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State	Place of Disposition (Name of Permetery, crematory or other place)	Ne 2004	20c. Location - City of Balthmore	or Town, State
Bal	permit. Departr Import. eny inj		21. Signature of Funeral Service Licer 23a Part 1. Enter the disease, or com shock, or heart failure. List only	Helle Dications that caused the deat	22. Name and Addres 8800 H/2 h. Do not enter the mode of dying	elsed ld B	, Funcial C. altimore P. tory arrest,	Approximate Interval Between
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	D.	fanlesse	Herran	Onset and Death
3760,	ite be executed sysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		uence of): unic Cand uence of): Alm son	ro my of solt	y	
P.O. Box 68	that the death certifica led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3 Ectopic pregnancy		23d. Date of d	elivery Day Year
	The law requires that the to have been signed by the bage 2 should be detached.	ρχ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying cause give		Did tobacco use contribute 1 Yes 2 No 3 F	to the cause of death? Probably 4 Dunknown
Division of Vital Records,		e Completed	BCVVVV 25. Was case referred to mildical	12 Pech	me mpetry	7	autopsy prior to death? Yes 2 □ No 1 □ Ye	autopsy findings available completion of cause of
Ĭ	hysicie nis cert I direct	To B	examiner? 1 Yes 2 No		ER/Outpatient 3 DOA		Residence 6 Other (Sp	ecify)
ision o	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			Yes 2 □ No	cribe how injury occurred	2/ Co. do Al
Ο̈́	ital or A		4 Homicide determined		ome, farm, street, factory, office	City	tion (Street and Number or F or Town, State)	
	he Hosp in 24 hou he Fune pletely fi	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, death occurred at the tim tion and/or investigation, in my op	e, date and place, and due to pinion, death occurred at the t	o the cause(s) and manner a time, date and place, and du	is stated. le to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Marl	MD 29c. License	number	29d. Date signed (Mor	nth, Day, Year)
	51		30. Name and address of person who	completed cause of death (Iten	821 N. Eutai	wst. Bala	Imore MI	Ó
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	uture			

			For State Registrar	State of Maryland		ent of He ate of D			giene leg. No. 2 (004	02923
	Physici /Medic Examin	al	Decadent's Name (First, Middle Las	aham AKINS	4b. C	ity, Town, or L	ocation of Deal	2. Date of Dea , Month	10 20	Year ty of Death	3. Time of Death 12:47AM
	Funeral Director		5. Social Security Number 6. So. Social Security Number 1.	X. ex MM 2□F 7. Age (in yrs. last	yrs. Ronti		HOUN! If Under 24 Hrs Hours Min		(Year)	9. Birthp Court	Place (State or Foreign 170,UA
	e Maryland 8e-f show	ctor		10c. City, T	own or Location	Town					1 ☐ Yes 2 № No
9	be filed within 72 hours after death with the Maryland stal Hygiene. de other than "natural", or items 23e or 28e-f show event, i're Madical Exariline from the motified at	y Funeral Directo	10e. Street and Number SOIS K5 MA 11. Marital Status 1 Never Married 250 Married	12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 □ No If Yes, Give	13. Was De	specify Cuban,	panic Origin? (S Mexican, Puer Specify:	Specify Yes or No-		ace - Americack, White,	can Indian,
21215-0036	d within 72 hours piene. r then "natural", Ine Madical Exe	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	Year or Dates:	16a. Decedent's U	Isual Occupati		rking	16b. Kind of B	MA	dustry
Maryland 2	e d a b	To Be C	17. Father's Name (First, Middle, Last)	ARRY AKENS				me (First, Middle, ural Route Numbe	FL	in 3	121
Baltimore, Ma	of Health ar of Health ar if Item 27 is or other trau		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	e of Disposition (etery, crematory)	Name of	DEO B	Date A	20c. Location	MARY	LAND
■ Balti	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Ucen	plications that caused the death.	22. Name	and Address Address Downward Down	ORD RO	Balter	NORL I	Cray	2/34 Approximate
	Physician /Medical Examiner		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each line. a	Acute	myde	ardial	infand	ień		Interval Between Onset and Death
8760,	Page Page	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequent		vad (anto)	Olyanse			Tears
P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat	ath 3 ⊟Ectopi	c pregnancy (specify)				ate of deliver	ery Day Year
	w requires that been signed by should be deta	þ	Part II. Other significant conditions o	ontributing to death but not resulting	ng in the underlyin	ng cause given	in Part I.		bacco use cor		he cause of death?
tal Records,		Completed	25. Was case referred to medical				De Blace et De	24a. Was a autop perfor 1 Yes ath (Check only or	med? 2/3 No	prior to co death?	opsy findings available impletion of cause of
Division of Vital	ing Phys n. After this funeral di	ation: To Be	examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	VOutpatient 3 Bb. Time of Injury	DOA Other: 28c. Injury a Work?	4 🗆 Nursing	Home 5 Resid	ence 6 🗆 Ot		(y)
Divis	of in	il Certification:	3 Suicide 6 Could not be determined				data and place	City or Tow	n, State)		al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	niner: On the basis of examination and manner stated.	n and/or investiga	29c. License	nion, death occ	urred at the time, o	date and place 29d. Date sign	e, and due to	Day, Year)
•	5		30. Name and address of pers which	completed cause of death (Item 2:	3a) (Type, Print)	Sui	3757. Le 20	O Reis	terstoi	~ 3	MD
	Sta Registi		31. Date filed (Month) Day, (ear)	32. Registrar's Signature	Annal)	,					- V ***********************************

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and Certificate of Death	Mental H	211	04 02	921
			1. Decedent's Name (First, Middle, Last)	2. Date of E	neg. No. —	3. Time of	Death
	Physic			Month JANU	Day	Year 2004 3'45	
j	/Medi Examii					1 7]
			GENESIS HOMEWOOD 6000 BELLONA AVE BAITI				
	Funeral Director		5. Social Security Number 212-18-8173 6. Sex 1 Months 1	8. Date of B (Mogth, I	Birth Day Year 915	9. Birthplace (State of Country)	r Foreign UUNA
_	and w		Usual Residence of Decedent 10a. Ştate 10b. County 10c. Çity, Town or Location				
	Maryli f sho	ō				10d. Inside Cit	
	1 the 7	rec	10e. Street and Number 10f. Zip Code		10g. Citizen of W		
	eath with	Funeral Director	907 EVESHAM AVE. 21212		4.3	S.A.	
21215-0020	led within 72 hours after death with the Maryland ygiene. Per then "neturel", or ltems 23e or 28e-f show It, the Medical Evantiner must be notitled at	5	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:	Specify Yes or N to Rican, etc.)	No- 14. Race Blace Specify.	e - American Indian, k, White, etc. : BLACK	
15-0	72 h(Be Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	rkina	16b. Kind of Bu	siness/Industry	
121	within ane.	idm	Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)	(Knig	HAR	THEARE	
d 2	filed v Hygie ther t	သိ	17. Father's Name (First, Middle, Last)	- /Eint Midd	le, Maiden Surname		<i></i>
lan	ld be ental	To Be	KICHARD SNEED LUCL	me (First, Middle WDA	ie, <i>Maiden Sum</i> ami MAE	Moy	
Maryland	s 1 and 2 should be filed within 72 h Health and Mental Hygione. tem 27 is marked other then "netu other traumatic event, tre Medical	۲	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ural Route Num	ber, City or Town,	State, Zip Code)	
	es 1 and 2 of Health of Item 27 i		DOROTHY FUTRELL DAVEHTER 907 EVESHAM AVE		LTD, MI)	21212	-
Baltimore,	0 0 T L		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Date		City or Town, State	
tim	permit. Pag Department Important: I eny injury c		4 Donation 5 Other (Specify)	2.5.04	- BERLIN	J, MARYLA	AND
Bal	permit. Pag Department Important: I eny injury o						
			Vanja Greeke 4905 YORK ROM			lARYCAND:	21212
	Dhysician	9	23a. Part1. Enter the disease, or controlications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory	arrest,	Approximate Intervel Betw Onset and De	reen
	Physician / /Medical		Immediate Ceuse (Final disease or condition resulting in death) a. Meteutatic Colors	· / · · A		Uniber and Ex	Batri
	Examiner		disease or condition resulting in death) Due to (or as a consequence of);	-CA.10	m 4:		
	D #	ner	Some a la grande all a la consequence all a la cons	Hour	ica	1	
	ate be executed hysician and the burial-transit	Examiner	D	, 000	(
8	De exe	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or es a consequence of):				
68760,	icate be ex physician s the buria	Medicai	that initiated events Pue to (or as a consequence of):				
	certific nding pl	√Me	La contraction of the contractio	.10			
Box	death cer ettendin d for use	clar					
<u>о</u> .	the d	Physician//	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.			ribute to the ceuse of	
	s thet med t	b P	1 Dementia, Mabeles type II	1	Yes 2□ No	3 ☐ Probably 4 DCU	nknown
Division of Vital Records,	requir been s should	Completed t		24a. Was	s an autopsy ormed?	24b. Were eutopsy fin- available prior to completion of cau	-
æ	e law e hes age 2	ρm			×	of death?	
ta	ifficate tor, pe		25. Was case referred to medical		Yes 2 No	1 ☐ Yes 2 ☐ N	10
<u> </u>	ysicie is cert direct	P B	examiner?		one) idence 6 □Other	(Canaih)	
0	g Ph ter th		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury et Work? 28c. Injury 28		how injury occurred		
010	endin eath. or: Af the fu	catic	2 Accident investigation M 1 ☐ Yes 2 ☐ No				
Ĭ	or Atterdition of the control of the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (. City or To	Street and Number wn, State)	or Rural Route Numbe	ər,
2	ortal or or or or or or or or or or or or or	ဦ					
	To the Hospital or Attanding Physicien: The law within 24 hours efter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edlcai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and/or investigation, in my opinion, death occurred at the time, date end place, examination and ex	and due to the red at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)	
	o the vithin Fo the complex		29b. Signature and title of certifier 29c. License number		29d. Date signed (
-	->		60140 annolymner 272			-04	
	H	-	30. Name and eddress of person who completed cause of death (Item 23a) (Type Print)			- (
			5601 lock Roven Blod Berthmore, W	we-			
	Stat	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registra	r	EED 0 4 2004				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 29,2004 **Physician** January George Harold Baird /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) HealthCare HADE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 XM 2 □ F Yrs. 78 408-38-2917 Tennessee Director Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Director MD N/ABaltimore 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? filed within 72 hours after death with or Items 23a 3665 Hineline Road 21229 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 No 5-24-44 If Yes, Give Year or Dates: 5-25-46 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced 5-25-46 "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene Importent; if item 27 is marked other than "na any injury or other treumatic even". Elementary/Secondary (0-12) College (1-4or 5+) 3 Dish Washer Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert Noah Baird Minnie Ethel Burton 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Velva L. Baird Wife 3665 Hineline Rd., Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1X Burial 2 □ Cremation 3 □ Removal from State ve Cemetery 2/5/2004 Lake City Temporal Pome, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Cemetery Tennesse 21 Signature of Funeral Service License WIRD 328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) influenza **Physician** mknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) しんいしょしきかんん Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autonsy performed? 21 No 1 ☐ Yes 2 ☐ No 1□ Yes the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ✓ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 5 Pending investigation 1 Natural To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 04735 Junuary 29, 2004 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21229 JON FALLK MD 900 caton Avenue 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar Spar V.

ORIGINAL

Registrar DHMH 17 Rev 1/2001

State

altimore, Maryland 21215-0036

0.0

Division of Vital Records,

ORIGINAL

book

Chistin Parker Hove MD 9901 medical Center Drive Rockvine Mary and 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

👺. Registrar's Signature

31. Date filed (Month, Day, Year)

FEB 0 4 2004

_			1- For State of M	laryland / Dep <i>Ce</i>	artment of Health and rtificate of Death	neg. r	ne 2004 0292			
	Physici /Medic		1. Decedent's Name (First, Middle, Last) DOROTHY DAUNER BALLI	ENTINE		2. Date of Death Month C 01/29/20	Day Year 3. Time of Death 6:23 a M			
*	Examir Funeral		404 010	「AL ge (In yrs. last birthday)	4b. City, Town, or Location of Dea BALTIMORE If Under 1 Year	th 4	4c. County of Death (NONE)			
	72 hours after death with the Maryland of natural; or itema 23e or 28e fehow of liteal Examinate must be notified at	r	304-09-1564	90 Yrs.	ocation	09/19/19	13 INDIANA 10d. Inside City Limits			
21215-0036		ted by Funeral Director	10e. Street and Number 8800 WALTHER BOUEET 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Education	ARD Ever in U.S. 13. No 16a, Dece	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1□ Yes 2▼ No Specify: dent's Usual Occupation	Specify Yes or No- rto Rican, etc.)	1 □ Yes 2 No Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: WHITE Kind of Business/Industry			
	filed within 72 hc Hygiene. other than "natus ent, tra Medical	e Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5 + 17. Father's Name (First, Middle, Last)	fife.	is kind of work done during most of we DO NOT use retired) HOMEMAKER 18. Mother's Na	orking me (First, Middle, Maide	OWN HOME			
Maryland	d 2 should be th and Mental 7 is markad o traumatic eve	To Be	FREDERICK DAU 19a. Informant's Name/Relationship (Type, Print)			NKNOWN)				
a)	ges 1 and tof Healing If Itam 2 or other			orney 307	W. ALLEGHENY	AVE . TOW:	SON, MD 21204 Location - City or Town, State			
Balti	permit. Pa Departmen Important: any injury once.	· ·	21. Signature of Funeral Service Licensee	2:		ENRY W. J	ENKINS & SONS CO			
90,	Physician and // // // // // // // // // // // // //	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of):	tontes Alberta		Approximate Interval Between Only 1 and Death			
	res that the deatr cortifica igned by the attending ph be detached for use as the		yslclan/Me	ysician/Me		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	127	23d. Date of delivery Month Day Year	
rds, P	.≡ ∽ m	by	Part II. Other significant conditions contributing to death	out not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?			
	(0	e Completed	e Complet	25. Was case referred to medical		00 Plan of De	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1		
	ding Phys n. After this funeral di	To B	examiner? 1 Yes 2 No Hospital: 1 Anpati 27. Manyer of Death 1 Stylatural 5 Pending 2 Accident investigation	urv 28b. Time o	nt 3 DOA Other: 4 Nursing I	ath heck on one Home 5 Residence 28d. Describe how inju				
	oital or Attendurs after deathurs after deathurs Diractor:	Certification:	4 ☐ Homicide Scientific building, e	jury - At home, farm, str tc. (Specify)		City or Town, Sta				
•	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Medical	29a. Certifier (Check only only) Medical Examiner: On the basis of and manner so title of certifier 29b. Signature and title of certifier	or in a samination and/or in	h occurred at the time, date and plac vestigation, in my opinion, death occ	urred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s) atersigned (Month, Day, Year)			
	Sta Registr		30. Name and address of person who completed call of LAWRENCE MILLS JR. M 31. Date filed (Month, Day, Year) 32. Regist	.D. 5601	Print) LOCH RAVEN BLY	VD.BALTO.,	, MD. 21239			

State of Maryland / Department of Health and Mental Hygiene 2004 02928 1 = For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 2, **Physician** 2004ar Richard Rumel Bradley , Jr. 12:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner of Bethesda Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yee) Oct. 16, 1 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**∑**M 2□F 90 1913 Georgía Yrs. Director 260-60-7117 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 11014 Gainsborough Road 20854 United States death v Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Navy 5+ Captain other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of 99 permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ev Ermina Wellhouse Richard Rumel Bradley, Sr. ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard R. Bradley, III /Son 822 Fordham Street, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ArTington National 1 X Burial 2 Cremation 3 Removal from State March 4 □ Donation 5 □ Other (Specify) 31, Cemetery 2004 Arlington, Virginia 22. Name and Address of FacilityRobert A. Rockville, Inc. 300 West I Rockville, Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue 21. Signature of Funeral Service Licenses once. M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Atherosclerotic Heart Disease Due to (or as a consequence of): burial-I Box 68760. by Physician/Medical Congestive Heart Failure as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No PO detached the 9 Unknown 9 Hoknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Prostate Cancer 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 41 Nursing Home 5 Residence 5 Other (Specify) မ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 XNatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check ont onel 29b. Signature 29c. License number 29d. Date signed (Month. Dev. Year) D53691 February 2, 2004 DX of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 6320 Democracy Blvd., Bethesda, Maryland 20817 Ajay Reddy, M.D. 31. Date filed (Month, Day, Year)... 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 30, 2004 4c. County of Deeth Sedwin Osborne January 9:05 AM Brauer 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) Oak Crest Village Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Days Hours 1 ☐ M 2 💢 F Yrs. 226-30-4168 May 22, 1930 West Virginia Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖁 No Maryland Baltimore Parkville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 8820 Walther Blvd. 21234 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3€ Widowed 4 Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Shipping Agent Commerce 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) u/k Osborne u/k u/k 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) <u> Tom A. Logan - Nephew</u> 601 Hemingway Drive, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/03/04 Baltimore, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014 23a. Pert1. Enter the its ease, or complications that cause if the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Stage Due to (or es a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

permit. Peges 1 and 2 should be filed w
Department of Health and Mentel Hygien.
Important: If Item 27 is marked other tha
any injury or other traumatic exception.

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

2

Funeral

Director

Hygiena. other than "tetural", or thams 23a or 28a-f show rent, the Medical Examiner must be notified at

with the Marylend

ettending physician and for use es the bunal-trensit Physician/Medical Exami signed by the e ģ Completed

The law requiras thet the daath certificeta be executed cate has been sig r, pege 2 should b Aftar this cartificate funeral diractor, peg death. within 24 hours efter death To the Funeral Diractor: / completely fillad in by tha

State

Be

2

Certification:

edicai

29a. Certifier

25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 5 Pending investigation Natural Injury 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

1 Scentifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier - mor

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

0.58646

Boulevard

29d. Date signed (Month, Dev. Year)

MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

January

1 ☐ Yes 2 ☐ No

30, 2004

1 Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Parkville

as M- 1) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Monias 8800 walther 31. Date filed (Month, Dey, Year)

32. Registrer's Signature FEB 0 4 2004

oaker

Registrar DHMH 16 Rev 6/95

			1 - For State Registrar	State o	f Ma	ryland / D	epa <i>Cen</i>	rtment of F tificate of I	lealth D <i>eath</i>	and Me	ental Hyg	giene Reg. No.	200) 4	02930
	Physicia	an	Decedent's Name (First, Middle, Linda Louise I	•							2. Date of Dea	ath Day	Y	ear	3. Time of Death
,	/Medic Examin		4a. Facility Name (If not institution, g		nber)			4b. City, Town, or	Februa		County of		10 13A W		
			Harford Memoria					Havre of			Data of Bird		Harfo		
	Funeral Director		5. Social Security Number 174–36–6078	Sex 1☐M 2DXF	7. Age	(In yrs. last birt	rs.	Months Days	Hours	Min.	B. Date of Birt (Month, Da Sep. 2.	y, Year)		Coun	lace (State or Foreign try) yland
	land		Usual Residence of Decedent 10a. State 10b. County			10c. City, Town	or Loc	ation						10	0d. Inside City Limits
	a-f she	ctor	Maryland Harfor	cd		Noi	cth	East							1 ☐ Yes 2 ☑ No
	with the	Directo	10e. Street and Number 10f. Zip Code 21901						10g. Citizen of What Country' USA			try?			
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If the sith and Mental Hygiene. If marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or De	rces? 2 <u>√</u> Z]No e			/as Decedent of H Yes, specify Cuba ☐ Yes 25100	ispanic Oi in, Mexica Specify		ify Yes or No- ican, etc.)		14. Race - Black, \	White,	
ה ה	72 hou natura ilcal E		15. Decedent's	15. Decedent's Education 16a. De			(Give kind of work done during most of working					16b. Ki	nd of Busin	ess/Ind	lustry
717	l within iene. r than "	Completed	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+) Iffe. DO NOT use retired)						Tra	nspor	tat:	ion		
	be filed tal Hyg d other event,	BeC	17. Father's Name (First, Middle, La.			'					First, Middle,		,		
7	should be nd Mental marked c	ဥ	Vernon Charles S 19a. Informant's Name/Relationship			19b.	Mailing	Address (Street			lian Le			te. Zin	Code)
Ĕ	Health ar Health ar tem 27 is other trau		Robert R. Barro		đ	10	7 5	Seneca Co					219		
allimore	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Straightful 2 Cremation 3 4 Donation 5 Other (Special Control of Con		State		, crem	ition (Name of atory or other place Lingham Ce		Da 2/4/20			cation · Cit		wn, State
	permit. Depart Import any inj		22. Name and Address of Facility MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009												
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final										Interval Between		
}	Physician /Medical	_									meyear				
	Examiner		Sequentially list conditions,	b											
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cuts. Enter Judachling Cause (Disease or injury that initiated events	consequence o	1):							171			
Š,	icate be executed physician and s the burial-transit	i Exa	resulting in death) Last	consequence o	f):										
	ficate b physic s the b	edicai		d											
.O. DOX	w requires that the death certil been signed by the attending should be detached for use a	Physician/Me	FEMALE: 3b. Was decedent pregnant in the past 12 mgnths? 1 □ Yes 2 □ No 9 □ Unknown 2c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown							23d. Date of delivery Month Day			•		
corus, r	quires that n signed by uld be deta	ě	Part II. Other significant containous contributing to death but not resulting in the underlying cause given in Part I.								e cause of death? ably 4 □Unknown				
חשבו	The law reate has bee page 2 sho	Completed									24a. Was a autop perfor 1 Yes	sy	deat	h?	psy findings available inpletion of cause of 2 No
7112	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	•			Cthe			Check only o				
CIVISION OF VICE NECCIONS, F.O. DOX	ng Phys fter this ineral di	on; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date o	npatien of Injury h, Day	28b. Ti		3 DOA 28c. Injury	at (?		5 ☐ Resid d. Describe h			Specify,)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification;	Accident Suicide City or Town, State)								Route Number,				
-	a Hospita 24 hours 5 Funeral stely filled	edical Co	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physician: To the	SIS Of E	examination and	death (occurred at the timestigation, in my op	ne, date ar pinion, dea	nd place, an ath occurred	d due to the o	ause(s) late and	and manne place, and	r as sta due to	ited. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1				29c. License					signed (M		
•	m		Charlete	Word O	め				1005	4439	1	Feb	mary	1,0	2004
			alt	30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Vivcent A. Gimmars Do Go 2 5, Atward Road, Suite 208 Bolder, Will 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature Signature Signature Signature											
	Sta Registr		31. Date filed (Month, Day, Year)	32. R	egistrar	's Signature	4	backs							

-BARROW LINDA LOUISE

				State of Maryland	d / Department of Health and I	Mental Hygiene	203.2.0	00001
		ľ	1 - For State Registrar	Oldio of Maryland	Certificate of Death	Reg. No	ZUUU	02931
	Dhusisi		1. Decedent's Name (First, Middle, Las	st)		2. Date of Death Month n Da	y Year	3. Time of Death
	Physici /Medio		Josephina	814		02 00	2 04	4:40 p M
	Examin	er	4a. Facility Name (If not institution, give	1/	4b. City, Town, or Location of Death	40	. County of Death	
			5. Social Security Number 6. S	ex 7 Age (In yrs. In	ast birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
16	Funeral Director			□M 25 90	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)		SSISSIPPI
	Q		Usuel Residence of Decedent	140.00				
	arylar show	_	10a. State 10b. County	10c. City	r, Town or Location			10d. Inside City Limits 1 ☑¥6s 2 ☐ No
	the M	ectc	10e. Street and Number		10f. Zip Code	10g Ci	tizen of What Cou	
	With With	Funeral Director	7520 Surra	itto Pd	20735	, isg. c.	11.5.	<i>A</i> .
	ms 2;	nera	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?		pecify Yes or No-	14. Race - Ameri	
9	or Ite	Ful	1 Never Married 2 Married	1 Yes 2 No	1 Yes 2 No Specify:	o Rican, etc.)	Black, White,	, etc.
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show the Mucical Exercities malles hallfisd a	d by	3 Nidowed 4 Divorced	Year or Dates:			121	ack
215-	in 72 in mat	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NDT use retired)	king 188. N	(ind of Business/fr	dustry
212	yiene.	ome	Elementary/Secondary (0-12)	College (1-4or 5+)	Housekeeper		Jomes	fic
	be filed tal Hygind other	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maider		
ylaı	Ment Ment arked	To	unknown		Prisc			
Maryland	2 sho	ii A	19a. Informant's Name/Relationship (511100 Ct 111	ral Route Number, City of	or Town, State, Zi	1
	1 and Health em 27 ther tr		Steven Leon 20a. Method of Disposition		lace of Disposition (Name of	-	ocation - City or T	own, State
Baltimore	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan crament of Health and Mental Hygiene. ortanti: if Item 27 is marked other than "natural; or items 23a or 28e-f show injury or other traumatic event, the Mudical Examinat must be naillised at a.		1 Surial 2 Cremation 3 C 4 Donation 5 Other (Specif	Hemoval from State	emetery, crematory or other place)	7. 2004 /Ca	meac d	Lu Mes
華	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licer		22. Jame and Address of Facility	1 2007 CC	nous co	dee P.A.
ñ	Depa Impo eny ir		Carlfon C.	Donalan	1701 Mc Culloh	St. Bal	16. led.	21217
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	AIZHPIME				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):			
	Examine.	1	Sequentially list conditions,	b. Due to for as a consequ	ience of:		-	
	uted 1 ansit	Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- VEGERGERAN				
ó	te be execu ysician and re burial-tra	Exa	resulting in death) Last	c. Due to (or as a consequ	uence of):			
3760,		cal		_ d				
x 68	that the death certifica led by the attending ph detached for use as th	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	***			-
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal	death 3 Ectopic pregnancy	K)	23d. Date of deliv Month	Pery Day Year
P.0.	y the	nysic	1 Yes 2 No 9 Unknown	9 Unknown	Sall Salls (specify)			
	law requires that the death as been signed by the atter 2 should be detached for u	y Pł	_ ,	- 1	ulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Records,	w require been sig should b	ed t	Aerviosclarutic	peripheli vss	ular Discuse	1 ☐ Yes 2	No 3□ Pro	bably 4 □Unknown
ecc	law re as be 2 sho	plet				24a. Was an autopsy	24b. Were autoprior to co	opsy findings available ompletion of cause of
33	The The page	Con				performed? 1 ☐ Yes 2 Ø No	death?	
Vital	Physician: The law this certificate has t	Be	25. Was case referred to medical examiner?	Hospital:		th (Check only one)	11/22 - 1	
of	Phy this	. To	1 Yes 2 No	1 Inpatient 2	ER/OutpatienI 3 DOA Nursing H	lome 5 Residence		fy)
On	Attending I r death. octor: After by the funer	tlon	1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	Injury Work? M 1 ☐ Yes 2 ☐ No		,, , , , , , , , , , , , , , , , , , , ,	
Division	Atter ctor by the	ifica	3 Suicide 6 Could not b	e 28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	28f. Location (Street ar City or Town, State		al Route Number,
Ö	rs after al Dir	Cert	Tomose	Dundang, oto. (Discon)	,	ony or rown, stare	=/	
1	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certification:	(Check only 2 Medical Exam	niner: On the basis of examinal	wledge, death occurred at the time, date and place tion and/or investigation, in my opinion, death occu	, and due to the cause(s) and manner as a	stated. to the cause(s)
	the the the the the the the the the the	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. Da	ate signed (Month,	Day, Year)
	7 × 0			me m		- 1		
	3		30. Name and address of person who	completed cause of death (Item	D35206		pury 2,	2007
)		William T. TA	NOWER MO 11-	101 Livingsty Rood Fat	WASHINGTH , M	nD.	
	Sta Regist		31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture Angell)	, ,		

			1 - For State Registrar	State of	Marylan		artment o				Reg. No.	300 H	02932	
	Obvoisie		Month Day Yeer										3. Time of Death	
	Physicia /Medic		Marie A.							Januar	y 29,	2004	11:35 p M	
	Examin	er	4a. Fecility Name (If not institution	-			4b. City, Tow Baltin		on of Death		4c. C	county of Deet	h	
	7.		Good Samaritan 5. Social Security Number		Age (In yrs.	last hirthday)	If Under 1 Ye		ler 24 Hrs.	8 Date of Bir	th	9. Birt	hplace (Stete or Foreign	
	Funeral Director		218-28-4468	1 M 2 🗗 F	92	Yrs.	Months Da			8. Date of Bir (Month, Da Dec. 29	iy, Year) , 1911	. Mar	yland	
	g ,		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	eation						10d. Inside City Limits	
	ahov	ŭ			100. 01	y, town or Lo			1 1				1 ☐ Yes 2 ▼ No	
	the M	ecto	Maryland Balti 10e. Street and Number	more			10f. Zip Coo	nesvi]	lle		10g. Citize	en of What Co	ountry?	
	with Ba or	ā	1752 White Oak	Avenue				1234			-	S.A.	,	
	ms 2	Funeral Directo	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13.			Origin? (Sr	pecify Yes or No Rican, etc.)		1. Race - Ame		
9	within 72 hours after death with the Maryland ene. than "naturel", or liems 23a or 28e-f ahow ha Magical Examiner is ust by mullied at		1 Never Married 2 Mar	If Yes Give	2 XNo		ir res,speciny t 1 □ Yes 2 🔂			э нісал, есс.)		Black, White Specify: whi	_	
21215-0036	hours urel',	Completed by	3 ∑Widowed 4 □ Divorced	Year or Da	tes:	,						d of Business/		
7	n 72	lete	(Specify only highe	nt's Education est grade completed)		(Give	dent's Usual Oc kind of work do DO NOT use re	one durina m	ost of worl	king				
77	withi iene.	ошь	Elementary/Secondary (0-12)	College (1-	4or 5+)	Assis	tant Vi	ce Pre	eside	nt	Rose	dale Fe	ederal	
ਰੂ	Hyg othe	Be C	17. Father's Name (First, Middle,	Last)			-	18. Mo	ther's Nam	ne (First, Middle	, Maiden S	umame)		
ylar	Menta Menta arked	ToE	John Knauer							rine Scl				
Maryland	id 2 sho lth and 27 is mu		19a. Informant's Name/Relations Carole Cecil- d							ral Route Numb Baltimo			zip Code) nd 21234	
ē,	s 1 and the Heal		20a. Method of Disposition		1 0	lace of Dispo	sition (Name o	f place)		Date	20c. Loca	ation - City or	Town, Stete	
Ë	Pages nent of P nnt: If its ury or of		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (5		itate !	reland	Cemete	ry		/2004			Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If Item 27 is marked other than "naturel, or Items 23a or 28e-f show any injury or other traumatic avant, the Madical Examiner must be notified at any injury or other traumatic avant, the Madical Examiner must be notified at any in.		21. Signature of Funeral Service	Licensee						ller-Dip altimore			l Home, Inc. 21206	
4			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Ons, and Death											
	Pnysician		Immediate Cause (Final disease or condition Networks 1994)											
H	/Medical Examiner		resulting in death) Due to (or as a consequence of):											
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence											
ó	icate be executed physician and s the burial-transit	Exa												
1760,		Ical		d										
89	ing ph	Med	IF FEMALE:	1										
P.O. Box	that the death certifica ed by the attending ph detached for use as th	by Physician/M	23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Fete	death 3	Ectopic pregna				23	3d. Date of deli Month	ivery Day Year	
0	the de	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)											
صِ	that the post of t	y Ph	7 417 11. 4 4 14 14 14 14 14 14 14 14 14 14 14 14							obacco us	use contribute to the cause of death?			
rds	w requires that s been signed t should be deta	q pa	OEmo	WMA -	- BL21	nome	86-140	6		10	Yes 2.j	2 No 3 Probably 4 □Unknown		
Division of Vital Records,	12 m	Completed								24a. Was auto perfo		24b. Were au prior to death?	utopsy findings available completion of cause of	
ita	ian: rtifica stor, p	Be C	25. Was case referred to medical examiner?	21				26. Pl	ace of Dea	th (Check only	-7			
<u>></u>	hysic his ce I dire	To	1 □ Yes 2 No		npatient 2				Nursing H	ome 5 ☐ Resi			cify)	
D C	Attending Physician: ir death, ector: After this certification in the funeral director, is	iuo	27. Manner of Death 1 Natural 5 ☐ Pendi	9	nt Injury h, Day Year)	28b. Time o Injury		Injury at Work?	□Na.	28d. Describe	how injury	occurred		
Sio	ttend death stor: / the f	icat	3 Suicide 6 Could		of Injury - At h	ome farm str	M reet, factory, off	1 Yes 2	□ INO	28f Location /	Street and	Number or Ri	ural Route Number,	
Ω	after after Direct d in by	Certification:	4 Homicide determination	nined 200. Flace buildin	ig, etc. (Specil	(y)	oot, lactory, on	100		City or To		710		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the I Examiner: On the ba and mann	isis of examina er stated.	ition and/or in	vestigation, in r	ny opinion, o	death occur	rred at the time,	date and p	place, and due	to the cause(s)	
	To th To th compl	Me	29b. Signature and title of contrib	er /	11	1	29c. Lic	cense numbe	θr		29d. Date	signed (Monti	h. Day, Year)	
	,		May	la the	hu	in		1.50	390	>	1	130/	2004	
	5		30. Name and address of person	who completed cause	e of death (Iter	m 23a) (Туре,	Print)	loch.	RAVE	-1 BL	w,	RA 110.	n, Day, Year) 2004 Mid 21234	
	Sta	ite	31. Date filed (Month, Day, Year) 32 A	egistrar's Signa	ature	notes						***	
	Regist	rar	CCD 0 4	2004	ANAS A	of the state of th								

					nent of Health and	Mental Hygi	ene 2001.	02020
		A	MEND ITEM #21 PER DVR G828 2/04/04	Jh Certifi	cate of Death		g. No. 2004	02933
	Physic	ian	1. Decedent's Name (First, Middle, Lest)			2. Dete of Death Month	Day Year	3. Time of Death
· Wall	/Medi	cal	John Cagle	1046	() () T	r Location of Death	1- 2004	319m
	Examii	ner	4a Fecility Neme (If not institution, give street and number)	100			4c. County of Death	
1-	Funeral		5. Social Security Number 6. Sex, 7. Ag		Under 1 Year If Under 24 H	(S. 8. Date of Birth	/V /A	place (State or Foreign
	Director		218-10-1690 1XM 20F	93 Yrs. Mo	nths Days Hours Mi	n. 8. Date of Birth (Month, Day, 1	Year 19/1 Moun	ntry)
	P .	•	Usuel Residence of Decedent			1 7 0 7	7. 17.141	grana
	arylei ehow	_	10a. Stete 10b. County	10c. City, Town or Location	1		11	0d. Inside City Limits
	he M	Director	Maryland N/A		ore			1 X Yes 2 □ No
	with		10e. Street and Number	1 + 4420 10	of. Zip Code	109	g. Citizen of What Coun	itry?
	72 hours efter death with the Marylend natural', or frems 23a or 28a-f show disal Examiner must be notified at	Funerai	11. Marital Status 12. Was Decedent I	>(.	Decedent of Hispanic Origin?	Specify Ves or No.	14. Race - America	ean Indian
0	or frer	F	Armed Forces? 1 ★ Never Married 2 ☐ Married 1 ★ Yes 2 ☐ N	If Yes	Decedent of Hispanic Origin? specify Cuban, Mexican, Pue	orto Rican, etc.)	Black, White,	
21215-0020	ours e	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1□ Y	es 2 No Specify:		Specify: Pla	ick
5-0	natural',	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's	Usual Occupation of work done during most of w OT use retired)	orking 16	3b. Kind of Business/Ind	dustry
121	within ene. than "	E E	Elementary/Secondary (0-12) College (1-4or 5	i+) life. DO No	OT use retired)	4	1 1 .	T 11
	TO 100 by 100	ပိ	17. Father's Neme (First, Middle, Last)	Longs	shoreman	ame (First, Middle, Ma	teamship	Irade Assoc
an	ould be fi Mentel H arkad ott attic ever	o Be	TI		18. Mothers N		C Sumame)	
Maryland	₹ P E E	F	19a. Informant's Name/Relations bype, Print) (Nie	C 0 19b. Mailing Ad	dress (Street and Number or I	Rurel Route Number (City or Town State Zin	Code
	nd 2 sith er		Mrs. Burnetta Parsor	and the second second	Penrose	AVO B	alto Nd	2/223
ïe,	of Hee		20a. Method of Disposition	20b. Place of Disposition cemetery, crematory	(Name of	Pate 20	Oc. Location - City or Tox	wn, State
Ĕ	Page:	- 1	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	A .	lle Cemetery	2/6/2004 (rownsvil	6 Md
Baltimore,	permit. Pages 1 en Depertment of Heal Important: If Itam 2 any injury or other once.	- 1	21. Signature of Funeral Service Licensee		e and Address of Facility	1 301		10,1101.
m	80 5 5 8	- 1	JOSEPH L. RUSS PER	DVR Jose	ph L. Kuss	s tunera	of Home	1216
			23a. Part Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin		mode of dying, such es cardi	ac or respiratory arrest	t,	Approximate
1	Physician		on of the second	0.				Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	BONIC 15	VAL FAILU	N C=		142
		*		Due to (or as a consequence				
	ted nsit	edicai Examiner	b					
	ficete be executed physician and ss the bunel-trensit	Exal	if any leading to immediate	Due to (or as a consequence	of):			
68760,	e be /sicia e bur	Ca	cause. Enter Underlying Ceuse (Disease or injury that initiated events					
			resulting in death) Last	Due to (or as a consequence	on.			
Вох	The lew requires thet the death certif ste hes been signed by the ettending page 2 should be deteched for use e.	by Physician/M	d					7
	e dea he ett hed fo	Sic	Part II. Other eignificant conditions contributing to death but	it not resulting in the underlyi	ng cause given in Part I.	23b. Did tobe	ecco use contribute to	the cause of death?
о. О.	d by t	£	DEMEMILA			1 🗆 Yes	2 ☐NO 3 ☐ Probe	ably 4 ☐ Unknown
Š	res the signe d be d	2						
Vital Records,	requ	Completed				24a. Was an a performe	d? avai	re autopsy findings ilable prior to apletion of cause
ee Ee	e lew hes t	ם						leath?
			05 W			1 □ Yes	2□No 1□	Yes 2□ No
	Physician: The lew this certificete hes t ral director, page 2 s	—	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Innation		Other	ath (Check only one)		
ō	ding Phy th. After this funeral d	<u>ان</u> 2	27. Manner eath 28a. Date of Injury		28c. Injury at Work?	dome 5 ☐ Residence 28d. Describe how	e 6 □Other (Specify)	
<u>0</u>	Attending or deeth. ector: After by the fune	턃	1 Taturel 5 ☐ Pending (Month, Dey 2 ☐ Accident investigation	Year) Injury M	Work? 1 ☐ Yes 2 ☐ No		,,	
	il or Attend efter deeth Director: / d in by the	<u>≅</u>	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur	ry - At home, farm, street, fac	ctory, office	28f. Location (Stree	at and Number or Rural	Route Number,
Ξ	taion rseft and Dir	Ser	4 Homicide building, etc.	(Эреспу)		City or Town, S	rare)	
1	To the Hospital or within 24 hours eftu To the Funeral Dir completely filled in	edical Certification:	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of 2 ☐ Medical Examiner: On the basis of the control o	my knowledge, death occur examination and/or investiga	red at the time, date and place	a, and due to the caus	e(s) and manner as sta	ited.
	Within 2 Within 2 To the Complete		one) and manner state 29b. Signature and title of certifier	ed.				
	8 4 %		255. Oignature and the or certifier		29c. License number		Date signed (Month, Da	
	1		30. Name and address of person who completed cause of dea	oth (Item DOs) (Torres Doin)	047945		E 12 5	2004
	,)		(AAA) ACT m my		EN PAINE	Rindlen	1 mp 21	7.04
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar			100-00		-0 9
	Registra	ir)	FFD 0.4.2004	H Lan	10° a			

DHMH 16 Rev 6/95

1-

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death

	0	0	0	0	1
,	U	6	7	3	Ī

п	Physician
	/Medical

RICHARD DANIEL CAMPBELL

2. Date of Death JAN 29, 2004

Reg. No.

3. Time of Death

Examiner

4a. Fecility Name (If not institution, give street and number)

4b. City. Town, or Location of Death

4c. County of Death

0910

Funeral Director

28a-f show

ral', or iteme 23a or 28a-f ehov Examiner roust be notified at

"natural",

The Mo

le marked

Department of Health as Important: If item 27 le any injury or other trac

Physician /Medical Examiner

burial-tran

attending physician

should be deta

page 2 s

certificate

After

death. filled in by the f

within 24 hours after To the Funeral Dire To the Hospital

the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

permit.

or Attending Physicien: The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

Baltimore, Maryland 21215-0036

5. Social Security Number 218-56-0071 Usual Residence of Decedent 10a. State Director by Funeral 1 Never Married 2 Married Completed

Be

Examiner

Physician/Medical

Completed by

Be

Certification; To

Medical

729 SOUTH MONTFORD AVENUE BALTIMORE CITY 7. Age (In yrs. last birthday) Months 1 0 M 2 □ F

If Under 1 Year | If Under 24 Hrs. Days Min

8. Date of Birth (Month, Day, Year) 12/24/48 Birthplace (State or Foreign Country) MARYLAND

10b. County VA. NELSON

1. Decedent's Name (First, Middle, Last)

MASSIES MILL

10c. City, Town or Location

10d. Inside City Limits 1 ☐ Yes 2 No

10e. Street and Number 309 RIVERSIDE LOOP 10f. Zin Code 22954 10g. Citizen of What Country? USA.

Specify.

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No

If Yes, Give Year or Dates:

College (1-4or 5+)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify:

Race - American Indian, Black, White, etc.

3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes 2 ☑ No

WHITE 16b. Kind of Business/Industry

Elementary/Secondary (0-12)

ELECTRICIAN

ELECTRICAL COMPANY

17. Father's Name (First, Middle, Last)

RICHARD W. CAMPBELL

18. Mother's Name (First, Middle, Maiden Surname) JULIANNA PITURA

19a. Informant's Name/Relationship (Type, Print) MISS LAURA CAMPBELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

BO9 RIVERSIDE LOOP MASSIES MILL, VA. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

atheroscleratic Cardiovascular

20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

BAYVIEW CREMATORY 1/31/04

BALTIMORE, MD.

21. Signature of Funeral Service Liçense

KACZORÓWSKI "FUNERAL HOME P.A. DUNDALK AVE. BALTIMORE.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

21222 Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

to (or as a consequence of):	
Due to (or as a consequence of):	

Due to (or as a consequence of)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

9 Unknown

3 □Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

Year

5 Pending

Part, II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24a Was an autopsy 2 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

25. Was case referred to medical aminer? Hospital: 1 Inpatient 1 XYes 2 □ No

investigation

6 Could not be determined

2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) AT SCENE

28c. Injury at Work? 28d. Describe how injury occurred 1 🗌 Yes 2 No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

2 Accident

3 Suicide

4 Homicide

1 ANatural

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

O.C.M.E

29d. Date signed (Month, Day, Year) 30, 2004 JAN.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUAKMD111 Penn Street, Baltimore, Maryland 21201 SONICA. 31. Date filed (Month, Day, Year)

State Registrar

FFR 0 4 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 16:04PM **Physician** ebruary 2004 Patricia Marie Connolly /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ralbimore City altimore HOS pital 0 N/A 1 mai If Under 1 Year | If Under 24 Hrs. | (8. Date of Birth (Month, Day, Year) | 09/25/1932 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 71 MD 218-26-4965 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Pasadena MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Iteme 23a 171 Arundel Road 21122 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Health Care 12 Secretary markad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental William Joseph Feehley Hilda Elizabeth Funk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) • permit. Pages 1 and 2 Department of Health a Important: If Item 27 Ie any Injury or other trai once. Patricia Williams/Daughter 613 Longview Dr., Catonsville, MD 21228 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Loudon Park Cem 02/07/04 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 169 Riviera Dr., Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Opset and Death Immediate Cause (Final disease or condition uravascula conqueah Physician disterninated resulting in death) /Medical Due to (or as a consequence of): Examiner organ 0 le Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No has 20 No certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. the f within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Ę. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -625 towar a~ 32. Registrar's Signature 31. Date filed (Month, Day, Year). ... State Registrar

DHMH 17 Rev 1/2001

1/0220

Known

			for State Registrar AMEND ITEM	State of M	aryland / Dep	artmen e <i>rtificat</i>	t of H	lealth and <i>Death</i>	Mental Hy	giene 2	004	02936
			Decedent's Name (First, Middle,	Last)	3 2/10/04 JH				2. Date of D		Yeer	3. Time of Death
_	Physici		Rose			Dar	den			Tebruary 3 2004 12:35P		
	/Medi Examir		4a. Fecility Name (If not institution,	give street and number))	4b. City,	Town, o	r Location of Dea	ith	4c. Coul	nty of Death	
			Joseph Riche					ore				
8	Funeral Director		212-56-7312 212-50-7312	6. Sex 7. Ag	ge (In yrs. last birthda) Yrs.	Months	1 Year Days	If Under 24 Hr Hours Mir	. (Month, D	irth Pay, Year) 22 48	Coui	place (State or Foreign ntry) ID
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	Location					1	10d. Inside City Limits
	Maryl f sho	ō	MD NA		Baltimo	re						1 X Yes 2 ☐ No
	36 s after death with the Marylan , or itams 23a or 28a-f show capiner must be motified at	Funeral Director	10e. Street and Number	·	.1	10f. Zip	Code			10g. Citizen	of What Cou	ntry?
	h with	a D	1837 East 29t	h Street			21	218		U	.S.A.	
	deat	ner	11. Marital Status	12. Was Decedent	t Ever in U.S. 13	If Yes, spe-	dent of H	lispanic Origin? (an, Mexican, Pue	Specify Yes or N into Rican, etc.)	o- 14. F	lace - Ameri lack, White,	
9	or its	y Fu	1 Never Married XXMarrie	If Yes, Give	No			Specify:		Spe	cify:	
Š	21215-0036 d within 72 hours att glene. or than "natural", or tra Medical Exarci	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		edent's Usua	al Occur	nation		16b. Kind of		31ack
L N	T5-in 72	Completed	(Specify only highes	t grade completed)	(Giv	e kind of wo	rk done se retire	during most of w d)	orking	100.71.10	3-01100011	,
2	Z1Z	luo	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)	Diet	Aid			H	ospit	al
	Ind 21215-U be filed within 72 hr tal Hygiene. d other than *natu event, Ine Medical	BeC	17. Father's Name (First, Middle, L	_ast)				18. Mother's Na	ame (First, Middl	e, Maiden Sum	ame)	
-	Venta by Wen	10	Arthur W. Ba	snight				Caroli	ne E. I	Lewis		
	Maryland 21215-0036 nd 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show rtraumatic event, the Medical Exerciting must be notified at	Ė	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Ma	iling Address	(Street	and Number or F	Rural Route Num	ber, City or Tov	vn, State, Zij	o Code)
	re, Maryla s 1 and 2 should f Health and Men item 27 is marke other traumatic		Willie Darder	-Husband	20b. Place of Dis			9th St	reet, I	altim 20c. Locatio		
	Or oth		20a. Method of Disposition 1		cemetery, ci	ematory or o	ther plac				•	
:	Baltimore, sernit. Pages 1 ar Department of Hea mportant: If item iny injury or otherone.		'4 Donation 5 Dother (Sp		King Me				6/04	Rand	allst	own, Md
	Baltimore, Ma permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any injury or other trau once.		21. Signature of Funeral Service L	- A Jhu	npain	March 1101	F/ Eas	H East t Nort	h Ave,	Balti	more,	Md 2120
	B		23a. Part1. Enter the disease, or shock, or teart failure. List	complications that cause only one cause on each	od the death. Do not e	enter the mod	le of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	* Physician		Immediate Cause (Final disease or condition	m	vetastatic	bre	as-	t canc	er			7415
Ž	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):							
104	LAMITMIE	<u>.</u>	Sequentially list conditions	b. Due to (or a	s a consequence of):		_				-	
T	ted last	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 4.	3 4 3011304331103 017.							
NY	60, be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	s a consequence of):							
	760 Ite be e lysiciar	cai		d								
2	ox 68 certificat oding phy use as the											-
10	Box 68 leath certifical attending phy	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		3 □Ectopic p	regnanc	v			Date of deliv	
13	death	sicis	in the past 12 months?			Other (s	pecify) _				Month	Day Year
14	P.O.	Phy	9 Unknown					i. D. M	an Die	I tehanan was s	aatributa ta i	the cause of death?
	လ် & ၉၆	by	Part II. Other significant condition	ahetes	but not resulting in the	unaeriying (cause giv	ven in Part I.	111	Yes 2 No		
	cords, w requires been sign should be	ted		anero					-			
2	Record he law requir he has been si age 2 should	Completed								is an 24 opsy formed?	 b. Were autoprior to co death? 	opsy findings available empletion of cause of
8	The cate h	ပိ							1 ☐ Yes	210 No	1 🗆 Yes	2E No
E	of Vital Rec Physician: The lav this certificate has al director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		-50	Ott		eath (Check only			
	Of Physic r this aral dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of In (Month, D			28c. Inju		Home 5 ☐ Re	sidence 6		MESPICE
3	ding h. After fune	tion	1 Natural 5 Pending		Say Year) Injun	M		rk?]Yes 2.⊟No				
3	Division I or Attending after death. Director: After	fica	3 Suicide 6 Could r	not be 28e. Place of I	njury - At home, farm,	street, factor	y, office				mber or Rur	ral Route Number,
	Div.	Certification:	4 Homicide	building, e	atc. (Specify)				City or I	own, State)		
	Division of Vital Rec To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the bes Examiner: On the basis and manner:	of examination and/or	ath occurred investigation	at the ti	me, date and pla opinion, death oc	ce, and due to th curred at the time	e cause(s) and a, date and place	manner as : e, and due !	stated. to the cause(s)
	o the ithin i	Med	29b. Signature and title of certifier			29	c. Licen:	se number		29d. Date sig	ned (Month,	, Day, Year)
	F 3 F 8	İ	> ZTSON				D 2	4170		Ehn	are cl	2004
	5		30. Name and address of person		death (Item 23a) (Typ	e, Print)		(1/5		10010	4	, 200
			CTO UN D.	they Hospic	e- 838	N.En	taw	St.	Baltim	ore, Mi	212	(2)
		ate	31. Date filed (Month, Day, Year)	2004 32 Regis	strar's Signature	Con .	-			,		
	Regis	rar	FFR U 4	LUUT REPORT	12 Si B							

			1 - For State Registrar	State o	f Maryla	ind / Depa <i>Cei</i>	artment tificate			and Mei	-	jiene og. No. 2 (004	02937
ı	Physicia	20	1. Decedent's Name (First, Middle	, Last)						2.	Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Ronald	н.		Deacon	Sr.			Fe	bruar		04	7:00 am ^M
2	Examin	er	4a. Facility Name (If not institution		mber)				ocation o			4c. County	of Death	
			1808 Belvue Dri						Hill					
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yr	rs. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	24 Hrs. 8. Min. Δ1	Date of Birth (Month, Day Ug. 2,	1 YPE/38		place (State or Foreign V1and
ì	Director		213-34-4487 Usual Residence of Decedent	X	65	115.				A	ug. 2,	1750	Tiat.	
	land ow	1	10a. State 10b. County		10c. (City, Town or Lo	cation						1	10d. Inside City Limits
	Mary -f sh fied	ģ	Md. Harfo	ord		Forest	Hill							1 ☐ Yes 2√∑ No
	r 288	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	ntry?
	h witi	<u>a</u>	1808 Belvue Dr	ive				21	L050			United	Stat	es
	deal	Funeral	11. Marital Status	12. Was Dec Armed Fo	edent Ever in	U.S. 13.	Was Deced	ent of His	panic Orig	gin? (Specify	y Yes or No- an, etc.)		ce - Americ	cen Indian,
Ö	or It	F	1 Never Married 2 Marri	ed 1 ☐ Yes If Yes. Gi	2 ⊡MANo ve		l ☐ Yes 2	-	Specify:	, , , , , , , , , , , , , , , , , , , ,	a., 0.0.,	Specif	W	hite
3	filed within 72 hours after death with the Maryland Hygiene. After than "naturel", or Itema 23a or 28e-f show ont, the Medicel Exeminer must be notified at	d by	3 Widowed 4 Divorced	Year or D	ates:									
ה	n 72 "nat	Completed	15. Decedent (Specify only highes	t arade completed)		16a. Deced	tent's Usua kind of wor DO NOT us	l Occupat k done du	ion iring most	of working		16b. Kind of B	usiness/ln	dustry
7 7	withii ene. than	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		nicia					stee	e1	
	filled Hygi other	ပိ	17. Father's Name (First, Middle, I		•				18. Mothe	r's Name (F	irst, Middle,	Maiden Surnan	ne)	
<u>a</u>	id be ental ked ic ev	0 B	Herbert Deacon						Ve	era Ki	ncaid			
2	shou and M amar umat		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	g Address	(Street ar	nd Numbe	r or Rural R	oute Number	, City or Town,	State, Zip	Code)
Ž	alth a		Theresa Deacon	/wife		1808	Belv	ue Di	rive,	Fore	st Hil	1, MD 2	21050	
ה ה	of He itam		20a. Method of Disposition			. Place of Dispo	sition (Nam	e of her place	, 1	Date		20c. Location -	City or To	own, State
Ĕ	Page nent ant: H		1 ☐ Burial 2天 Cremation 1 ☐ Donation 5 ☐ Other (Sp		1	avview	Crema	tory	2	2/3/04		Baltimo	ore,	MD
Dailing	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.		21. Signature of Funeral Service I	icensee	//	1 22	. Name and Schi	d Address mune	of Facility k Fun	neral	Home o	of Bel A	Air,	Inc.
	00 E 8 0		- a	ar			610	W. M	acPha	il Ro	ad. Be	1 Air.	MD 2	1014
			23a. Part1. Enter the disease, or shock, or heart failure. List of	only one cause on e	ach line.						spiratory arr	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	JIAI	36TE.	7	7F1	ZIT	us				
	Examiner			Due to	rasacors	equence of):	25							
d		ا و	Sequentially list conditions,	b. Due to	or as a cons	equence of):	N 7	0 =	7				-	
	uted d ansit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		STR	NKG								
Š	an an rial-tr	Exa	resulting in death) Last	Due to	(or as a cons	equence of):								
200,	ate be executed hysician and the burial-transit	icai		d.										
ŏ	artifica ing ph e as t	Med	IF FEMALE:						00					
	ath co	lan/	23b. Was decedent pregnant in the past 12 months?		oirth 2 Fe	etal death 3	Ectopic pre						te of delive	ery Day Year
	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9□ Unkn	nant at time of own	rdeath 5L	Other (spe	ecify)						,
Ĺ	that the ed by detac	H.	Part II. Other significant conditio	ns contributing to d	eath but not r	esulting in the u	nderlying ca	use giver	n in Part I.		23e. Did tol	pacco use cont	ribute to th	he cause of death?
STO CICA	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the buriat-transit	d by				·					1 🗆 Ye	es 2 🗆 No	3) Cob	pably 4 ∐Unknown
5	w req	lete									24a. Was a	n 24b.	Were auto	psy findings available
ב	The la te ha: age 2	Completed									autops perforr	ned?	prior to co death?	mpletion of cause of
ğ	an: tifica tor. p	0	25. Was case referred to medical						26. Place	of Death (C	1 ☐ Yes :		1 🗌 Yes	20,40
>	lysici iis cei direc	To B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3□ DO	Other				ence 6 Oth	er (Specif	(v)
5	ng Ph fter th neral		27. Manne of Death Natural 5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28	c. Injury a	at			ow injury occur		
2	tandi leath. tor: A the fu	cati	2 Accident investig	ation			М		es 2□N					
2	or At after of Direct in by	Certification:	4 Homicide determi	and 200. Flace	of Injury - At ing, etc. (Spe	home, farm, str cify)	et, factory,	office		28f.	City or Town	reet and Numb n, State)	er or Rura	Il Route Number,
	spita nours neral		29a. Certifier 1 ertifying	g Physician: To the	best of my k	nowledge, death	occurred a	it the time	, date and	d place, and	due to the ca	ause(s) and ma	nner as si	tated.
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical E	examiner: On the b	asis of exami ner stated.	nation and/or inv	estigation,	in my opi	nion, deat	h occurred a	at the time, d	ate and place,	and due to	the cause(s)
	With To t	Σ	29b. Signature and title of a rtifier	2	100	\	29c.	License	number	411	2	9d. Date signer	d (Month,	Day, Year)
	α		30 Name and address of person	NO	~~1		_ [.],	ノム	68	10	t	CISKU	11/	2,2000
	10		30 Name and address of person	who comulated sus	se of death (It	em 23a) (Type,	562	94	NG-6	ORNE	n Rop	m WI	475	Horlma
	Sta		31. Date filed (Month, Day, Year)	39. F	legistrar's Sig	nature		•						21161
×	Registr		FFR 0 4 2	004 Fal	WAS A	K ANDREW	Res.							- /
		-	N Sweet band	-40										

			1 - For Stata Registrar		ryland / [epartment		and Mental Hy	•		02	030
			Decedent's Name (First, Middle, La	est)			or Dodin	2. Date of D		20 4	3. Time of I	Death
	Physici	an	(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				-	Month	Day	Year		
4	/Medic		Jack	Mi_1	ler	Dai		Feb.			7:05	P ^M
1	Examir	er	4a. Facility Name (If not institution, gi			4b. City,	Town, or Location of	of Death	4c. County	of Death		
			8118 Quarterf				vern	0411			unde l	
	Funeral			·	(In yrs. last birt	hday) If Under Months	1 Year If Under Days Hours	Min. 8. Date of B (Month, D April	irth	Coun	ace (State or try)	Foreign
	Director		337 20 7033	XX	73	115.		Aprii	6,1930	Illi	nois	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Location				1:	0d. Inside City	v Limite
	sho	č			Seve					, ,	1 ☐ Yes	
	Ba-1	ect		under								-A-A
	A P	Director	10e. Street and Number			10f. Zip			10g. Citizen of V	Vhat Coun	try?	
	ath v	rai	8118 Quarterfie				21144		USA			
	ar de terms	by Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Decede If Yes, spec	ent of Hispanic Ori ify Cuban, Mexican	gin? (Specify Yes or N i, Puerto Rican, etc.)	o- 14. Race Blace	e - America k, White, e	an Indian, etc.	
98	afte of a	Ē	1 ☐ Never Married X X Married	1 1 Yes 2 □ No If Yes, Give		1 ☐ Yes 2				WHI		
21215-0036	within 72 hours after death with the Maryland ene. Than "naturel", or Items 23a or 28a-f show he Mardical Examinar must be notified at	d b	3 Widowed 4 Divorced	Year or Dates:	948-73				Open,	· W II I		
Ŋ	72 r	Completed	15. Decedent's E (Specify only highest gr		16a.	Decedent's Usual (Give kind of world	k done during mos	t of working	16b. Kind of Bu	isiness/Ind	ustry	
<u>2</u>	Athin na.	E E	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT us	e retired)					
N	filed w Hygier Sther tl	Ş	12		01	ficer			U.S. N			
힏	tal H	Be	17. Father's Name (First, Middle, Last)				er's Name (First, Middle	e, Maiden Sumam	θ)		
<u>Ja</u>	Ment Ment Marke Marke Marke	2	Clyde Daily				Zula	Hines				
Maryland	and and is my		19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address	(Street and Number	er or Rural Route Numb	er, City or Town,	State, Zip	Code)	
	and sealth m 27		Susan A. Daily	(Wife)	81	18 Quart	erfield	Farms Rd.,	Severn,	MD 2	1144	
<u>s</u>	item of He	l (20a. Method of Disposition		20b. Place of	Disposition (Nam	e of her place)	Date	20c. Location -	City or To	vn, State	
Ĕ	Pages nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Speci		I.	nd Vet.		/5/2004	Crownsv	ille.	MD	
Baltimore,	글로판출 .	k i	21. Signature of Funeral Service Lice	nsee	, 1101	22. Name and	Address of Facilit	v	0.5			1
m	Depa Impo any is		Dat f	11		Hardes	sty Fune	eral Home	P.A. G.) I AI	nnapo.	MD MD
			23a. Part1. Enter the asease, or com shock, or heart failure. List only	plications that caused to	ne death. Do n	ot enter the mode	of dying, such as	cardiac or respiratory a	arrest, .		Approximate	
0	DI:		shock, or heart allure. List only Immediate Cause (Final	one cause on each line		CAR	Con all A	00 1110	1	,	Interval Betwo	een eath
**************************************	Physician /Medical		disease or condition resulting in death)	a /4/2/745	THIK	- THE	THENT	07 /17	CUNC	<u>}</u>	Man,	1115
	Examiner		1	Due to (or as a	consequence c	1).						/
		<u>ت</u>	Sequentially list conditions,	b. Due to (or as a	Consequence o	f).		-				
	ted nsit	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•	'	,						
_	al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence o	f):				_		
9	ate be executed hysician and the burial-transit	caiE			·							
68760,	phys phys the		Conta	_ d						-		1
ox 6	death certifica e attending phy id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy							
8	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2	Fetal death	3 ☐Ectopic pre			23d. Date Mon	e of deliver oth		ar
o.	0 0 0	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tii 9□Unknown	ne of death	5 ☐ Other (spe	ecity)				,	
٥.	that the de led by the a detached f		Part II. Other significant conditions	contributing to death but	not resulting in	the underlying on	usa awan in Part I	23a Did	tobacco use contri	ibuta ta th	nouse of do	oth?
Š,	8 5 8	Completed by	14 000 - 60 60	-44	not resulting in	the diluenying ca	use given in Fait i.					
Record	w require been signature should b	ted	1 7 7 70 003 4	-000			6		Yes 2□No	3 [F10Da	bly 4 ⊟Un	KIIOWII
ec	las b	ğ	MARISCU	rotte 6	refug	y Tr	Try VI	35452 24a. Was	psv p	rior to com	sy findings av pletion of cau	/ailable
		등	HUSTACY FINTS	achier.	x Ital	1. RRI	LANG	perfo 1 ☐ Yes	ormed? d	eath? □Yes 2		
Vital	Attending Physician: r death. sctor: After this certific: by the funeral director.	Be	25. Was case referred to medical examiner?	/	1/0	, ,	26. Place	of Death (Check only	one)			
~	Physic this co	ဂ္	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Out	patient 3 DOA	Other: 4 🗆 Nur	rsing Home 5 Resi	dence 6 □Othe	r (Specify)		
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Ti	me of 28 jury	c. Injury at— Work?	28d. Describe	how injury occurre	bd		
Ö	ottendia death. ctor: A y the fu	aţi	2 Accident investigatio			М	1 □ Yes 2 □ N	No				
		Certification;	3 Suicide 6 Could not be determined		· At home, fari	n, street, factory,	office	28f. Location (City or To	Street and Numbe	r or Rural	Route Numbe	ər,
	talor Arsafter safter al Director by ed in by	Cer		8	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				,,			
	e Hospital 24 hours a e Funeral letely filled	cai	29a. Certifier 1 Certifying Pl	nysician: To the best of miner: On the basis of e	my knowledge,	death occurred a	t the time, date and	d place, and due to the	cause(s) and mar	ner as sta	ted.	
	To the Hospital or within 24 hours affe To the Funeral Discompletely filled in	edicai	one)	and manner state	d.	or investigation, i	opimon, deat	n occurred at the time,	date and place, a	na aue to t	ne cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of carallier	5	1	29c.	License number	/	29d. Date signed	(Month, D	ay, Year)	
					> 14	D. C	19971	′	2/03/	200	· f	
	01		30. Name and andress of person who	completed cause of dea	th (Item 23a) (ype, Print)	n /	>	1 /	7	106.1	
	10	4	DAYSO FEEE . M.D. S	MJE 41 2	2001kg	Property	Jean (1	EN Busa	PE M.	and.	BI	
	Sta	te	31. Date filed (Month, Day Year)	200 432. Redistrate	Signature	1			10	1-66	The state of the s	
	Registr	ar	LED	•								

			For State Registrar	State of Maryland / I		ment of He			giene 20	04	02939
	Physici		1. Decedent's Name (First, Middle, Last,	5.		Der	da	2. Date of Dea Month	oth Day	Year	3. Time of Death
X	/Medic Examir		4a. Facility Name (If not institution, give Haybor Hospita	l center		Baltin	ocation of Death		4c. County o	f Death	
	Funeral Director		5. Social Security Number 6. Sep 215-05-7598 15 Usual Residence of Decedent	7M 2015		f Under 1 Year lonths Days	Hours Min.	8. Date of Birth (Month, Day 3/15/	, Year)	9. Birthplac Country MARY	ce (State or Foreign) LAND
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Evaninar must be notified at	eted by Funeral Director	10a. State 10b. County MD N/A 10e. Street and Number 6811 BOSTON AVI 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade)	12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 □ No If Yes, Give Year or Dates: المنافذة المن	13. Was	10R E 10f. Zip Code 2122 Decedent of His as, specify Cuban Yes 250No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race Black, Specify: 16b. Kind of Bus	- American White, etc	Indian, TE
ind 2121	be filed within ital Hygiene. Id other than "event, the Me	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) THOMAS S. DERDA	College (1-4or 5+) CR		OPERAT	18. Mother's Nam	e (First, Middle, i	BALTIM Maiden Surname,		CITY
, Maryland	and 2 should lealth and Menim 27 is markenher traumatic	To.	19a. Informant's Name/Relationship (Ty, MR . MELVIN DERI	рө, <i>Print</i>) 19b ОА 38	309 G	RENTON	nd Number or Run		r, City or Town, S RE, MD		ode) 206
Baltimore,	permit. Pages 1 Department of H Important: If iter any injury or oth		20a. Method of Disposition 1 DBurial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ucense	HOLY	ROSA	RY CEM	E. 2/7/ Kff ^{aci} fyUNE	O4 RAL HO	DUNDALIME P.A. IMORE,	K, MI	
8760,	icate be executed Medical Examiner the burial-transit	dical Examiner	23a. Part1. Enter the disease, promplishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause ibusease or injury that intitated events resulting in death) Last	cations that caused the death. Do not be cause on each line. Supsis Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	of):					Alno (1)	pproximate terval Batween nset and Death 3 clays
O. Box 6	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		opic pregnancy ner (specify)			23d. Date Month	-	y Year
ords, P.	w requires that lhe de been signed by the a should be detached t	ρχ	Part II. Other significant conditions con	tributing to death but not resulting in		lying cause given	in Part I.		oacco use contrib es 2 🗷 No 3		eause of death? y 4 □Unknown
al Reco	n: The law r icate has be r, page 2 sh	Completed	Hypertensi	on				24a. Was a autops perform 1 Tes 2	y prid ned? dea	re autopsy or to compl ith? Yes 25	findings available etion of cause of
Division of Vital Records,	To the Hospital or Attending Physicien: The la within 24 hours after death. To the Funeral Director: After this centificate has completely filled in by the funeral director, page 2	atlon; To Be	25. Was case referred to medical examiner? 1 Yes		Time of Injury	DOA Other: 28c. Injury a Work?	it	me 5 Reside	e) ince 6 Other iw injury occurred		
Divis	ital or Atte irs after dea ral Directo led in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)				City or Town			
,	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☐ Medical Examinate 29b. Signature and title of certifier	ician: To the best of my knowledge er: On the basis of examination and and manner stated.	e, death occ nd/or investi	curred at the time gation, in my opin	ion, death occurr	ed at the time, da	use(s) and mann ate and place, and	due to the	e cause(s)
)	2 W T 0		30. Name and address of person who co	mpleted cause of death (Item 23a) (RES	100		Februar	y 01	
	Sta Registr		Tan Min 31. Date filed (Month, Day, Year) FER 0 4 2004	32. Registrar's Signature	back		er SE	· Dart	an ore	1417	21225

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pay 29 **Physician** EDWIN DANNER ANVARY 02:30AM 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW CARE CENTER BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year MAY 14, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F 220-14-3541 Director MD. Usual Residence of Decedent 10a. State wode | 10c. City. Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23a or 28a-f ebov treumatic event. Ite Mudical Exeminat must be notified at Funeral Director 1 ☐ Yes 2 ☐ No BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7587 IVES LANE. APT. E 21222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 1 4 5 2 No It 1 94 Year or Dates: 1 94 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ρ 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10TH other then College (1-4or 5+) FINANCIAL MAIL CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be f h and Mental I HOWARD E. DANNER EFFIE EILEEN STRUDVENT and A 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 ls EVELYN DANNER/WIFE 7587 IVES LANE, APT. E, BALTIMORE, MARYLAND 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department c Important: If any injury or once. injury or PARKWOOD CEMETERY 2/2/2004 BALTIMORE, MARYLAND 21. Signature of Funer Service License 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a Part 1 Enter the disease option iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 18 HOURS /Medical Due to (or as a consequence of) **Examiner** OSTRIDIUM DIFFICILE COLITIS 4 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit and Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown REPUBL DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2☒ No 24a. Was an has autopsy performed? CORONARY ARTER 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 478 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature an itle of certifier 29c. License number D33316 who completed cause of death (Item 23a) (Type, Print) Bellanton 5505 Hopkins Bryvier Circle Battime MOZICZY Michele mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 4 2004 Registrar

		•	For State C	of Maryland / Dep <i>Ce</i>	artment of Healt	th and Mo ath	ental Hygie	and an other f	02941	
,	Physicia	an	Decedent's Name (First, Middle, Last)		ELKIN		2. Date of Death Month FEBRUARY	^{Day} , 2004	3. Time of Death 6:50 AM	
À.	/Medic	al	GRIGORY 4a. Facility Name (If not institution, give street and no	mber)	4b. City, Town, or Local		FEDRUARI	4c. County of Death		
137	Examin	er	JEWISH CONVALESCENT CE		BALTIMORE			BALTIM	IORE	
	Funeral Director		5. Social Security Number 6. Sex 1 1 M 2 F	7. Age (In yrs. last birthday 87 Yrs.		nder 24 Hrs. urs Min.	8. Date of Birth Month, Day, Y JAN 19, 1	9. Birth	place (State or Foreign Intry) RUSSIA	
	land w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits	
	Mary Fe sho	tor	MD N/A	BAL	TIMORE				1 ☐ Yes 2 ☐ No	
	th the	Director	10e. Street and Number		10f. Zip Code		10 g	Citizen of What Cou		
	ath w	rai	3615 FORDS LANE #606			21215	oifu Von os No	14. Race - Amer	U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show importent: If item 27 is marked other than "natural", or items 23a or 28e-f show importent; if items 27 is marked other traumatic event, the Marylad Ex. infret man be notified at once.	by Funeral	Armed F	2 X No	Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 No Spec	ic Origin? (Spe exican, Puerto F ecify:	city tes of No- Rican, etc.)	Black, White		
Maryland 21215-0036	hin 72 hou s. tn "natura Macical E	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College) (Giv	edent's Usual Occupation e kind of work done during DO NOT use retired)	most of working		b. Kind of Business/I	ndustry	
2	ygiene ygiene yer tha	Сош	4		LOGIST		, , , , , , , , , , , , , , , , , , ,	GEOLOGY		
and	ntal H	Be	17. Father's Name (First, Middle, Last) ISRAEL	ELK		SARAH	(First, Middle, Ma	_	KNOWN)	
3	should be ind Mental I	T _O	19a. Informant's Name/Relationship (Type, Print)		ling Address (Street and N		Route Number, C			
	and 2 ealth a n 27 is		DVONYA ELKINA / WIFE	1100	5 FORDS LANE					
Baltimore,	Pages 1 nent of He int: If item iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from	State	ematory or other place)	1		c. Location - City or 1		
Ħ.	rtment rtent: njury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	HAR SINA	I CEMETERY 22. Name and Address of F	2/2/2 Facility SO		OWINGS MI ON & BROS		
Ba	permit. Departimports imports eny inj		Jaim 1		8900 REISTE					
+23			23a. Part1. Enter the disease or complications that shock, or heart failure. List only one cause on	caused the death. Do not el	nter the mode of dying, suc	ch as cardiac o	r respiratory arrest	,	Approximate Interval Between	
	Pnysician	0 1	Immediate Cause (Final disease or condition resulting in death)	YOCARDIN	n INI	ARC;	non	May	Onset and Death	
	/Medical Examiner		Que to	(r as a consequence of):			- 100 W			
	₩ 6 = 4	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of)						
	scuted ind transit	Examiner	that initiated events c	(A)						
8760,	icate be executed physician and s the burial-transit	ai Ex	Due to	(or as a consequence of):						
687	ficate g phys	edica	d							
Вох	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	230. Was decedent pregnant	utcome of pregnancy birth 2 Fetal death 3	☐Ectopic pregnancy			23d. Date of deli	very Day Year	
о. Ш	that the death cer ed by the attendir detached for use	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)					
۵.	w requires that the state of the signed by should be detact	by	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in l	Part I.	23e. Did toba	cco use contribute to		
Vital Records,	law requires as been sign 2 should be	Completed					24a. Was an	24b. Were au	topsy findings available ompletion of cause of	
Re	0 4 9	mo					autopsy performe 1 \(\text{Yes} \) 2 \(\text{V}	d? death?	2 No	
/ita	ysicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?			Place of Death	(Check only one)			
of	× 5	- T	27. Mann of Death 28a. Dat	Inpatient 2 ER/Outpati		_	ne 5 🗆 Residend 28d. Describe how	ce 6 Other (Specinjury occurred	ify)	
ion	Attending I r death. ector: After by the funer	atlon	1 Natural 5 Pending (Mo	nth, Day Yeer) Injury	Work? M 1 ☐ Yes	2 🗆 No				
Division	ii or Attend after death I Director: A d in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Place	te of Injury - At home, farm, s ding, etc. (Specify)	street, factory, office	1	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,	
/	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 12 Certifying Physicien: To II 2 Medicel Examiner: On the and ma							
	To the within To the	Me	29b. Signature and title of certifier	_	29c. License num	mber	290	. Date signed (Month	n, Day, Year)	
	i		1 thin mi	mla 1	My 1/51	140	1-	2515.17	hoot	
	M		30. Name and address of person who completed ca	use of death (Item 23a) (Type	Print) De HE	5 M	e, B.	MIMI	1 7115	
	Sta	ate		Registrar's Signature	the state of the s		1		N	
	Regist	rar	FFB 0 4 2004	and fine						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20014 Genevieve Firestone January 2:45 a M /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 955 Gambrills Lane Gambrills Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Oct. 2,1920 Birthplace (State or Foreign Country) Funeral Days Hours 1 ☐ M 2 💢 F Director 172-16-4346 83 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f ahow event, the Medical Examinar must be notified at 1√Yes 2 No Director Connellsville Fayette 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 696 Englishman Hill Road 15425 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 If Yes, Give Year or Dates: Specify White 3 Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Laborer Anchor Hocking Glass Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cyril Welsh Letty McCartney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Patricia Thomas (Daughter) 513 Bennington Road, Hopwood, PA 15445 Hem 20a. Method of Disposition 20c. Location - City or Town, State Department of Silbaugh Vault and = 0 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Importent: It any injury o once. * 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2004 Uniontown, PA Burial Service permit. Name and Address of Facility
Hardesty Funeral Home, P.A 21. Signature of Funeral Service Licenses 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6m 25 disease or condition resulting in death) Due to (or as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. physician use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ NO 23d. Date of delivery 3 Ectopic pregnancy ö Month Day Year 5 Other (specify) P.O. | ed by the a 9□ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy performed? 1 Yes 2 L or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence Other (Specify) Residence 1 ☐ Yes 2 ☐ NO Medical Certification; To 2 ER/Outpatient 3 DOA funeral dir 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel [
completely filled filled Fo the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical Exa 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35848 e of death (Item 23a) (Type, Print) 438Defense 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

				ate of Maryl	land / Depa		lealth and l	Mental Hy	giene 200	4 02943
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Yea	3. Time of Death
	Physici /Medio		PALMER HOWARD	FUTCHER				Month	29 200	6:25 AM
A. C.	Examin	er	4a. Facility Name (If not institution, give stree	t and number)			r Location of Deatl	h	4c. County of De	
		ш	BROADMEAD	7 Ago (la	use lead histhelead	COCKEY:	SVILLE If Under 24 Hrs.	9 Date of Rin	BALTIMO	
9"	Funeral Director		5. Social Security Number 6. Sex 120-30-2955		yrs. last birthday)	Months Days	Hours Min.	8. Date of Bir (Month, Da 09/13	71910 MAT	inthplece (State or Foreign Country) RYLAND
			Usual Residence of Decedent					03/13	, 1310 1111	(TEIN)
	nylani how		10a. State 10b. County	100	c. City, Town or Lo					10d. Inside City Limits
X	e Ma	cto	MD BALTIMORE		C0(CKEYSVI	LLE			1 ☐ Yes 2 No
P	or 2	Dire	10e. Street and Number			10f. Zip Code	20		10g. Citizen of What (Country?
	n 72 hours after death with the Maryland "naturel", or Items 23e or 28a-f show volcal Examinat mast be recitied at	Completed by Funeral Director	13801 YORK RD	Van Danadast Svor	in II C 12 V	210		posity Vac or Na	USA	nerican Indian,
0	ter de Item	-un-	11. Marital Status 12. V	Vas Decedent Ever med Forces? ▼Yes 2 □ No	10.5.	Vas Decedent of H Yes, specify Cuba	in, Mexican, Puert	o Rican, etc.)	Black, Wh	
38	hours after turel', or the	by		Yes, Give Year or Dates: W/W	יוער	☐ Yes 2 No	Specify:		Specify: WI	HITE
500	72 ho	ted	15. Decedent's Educatio (Specify only highest grade cor	n	16a, Decec	ent's Usual Occup	ation during most of wo	rkina	16b. Kind of Busines	s/industry
21	within 72 ane. than "nat	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done o		9	DIMOTOT	
04 $6:3$ Maryland 21215-0036	be filed within tal Hygiene. ed other than event, the Mu	CO	17. Father's Name (First, Middle, Last)		MED.	ICAL DO		ne /Eiret Middle	PHYSICIA Maiden Sumame)	AN
anc	0 = 0 e	Be	THOMAS B. FUTCHE	R				IE HOW.	,	
J. Z	2 should be and Mental is marked reumatic ev	은	19a. Informant's Name/Relationship (Type, F		19b. Mailin	a Address (Street			er, City or Town, State	Zip Code)
Ma	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other treumatic		JANE P. FUTCHER(. 1				,CA. 9494	
re,	ges 1 and 2 it of Health if Item 27 i		20a. Method of Disposition	1	Ob. Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location - City	or Town, State
2 S	Pages nent of i int: if it ary or o		1 Burial 2 □ Cremation 3 □ Remo 1 □ Donation 5 □ Other (Specify)	val from State	GREEN MO			/2004	BALTO. 0	CITY, MD.
1/29	in party in		21. Signature of Funeral Service Licensee	· ·		. Name and Addre				
\ <u>B</u>	Dem Perm Perm Perm Perm Perm Perm Perm Pe	V I	Willian (. la	WIII	1.0	ENRY W. 5924 YO	RK RD M	ONKTON	MD 2111	
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call timmediate Cause (Final disease or condition	ons that caused the duse on each line.	death. Do not ent	er the mode of dyin	g, such as cardia	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):	Th	1272	1 (1.	(2.26
	4	70	Sequentially list conditions,	Due to (or all a cor	nsequence of):	1112 m	69515	1011	UN	J-WEIKS
	petr I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	555 15 (5. 5)					0	
o . 6	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a cor	nsequence of):					
792	e ys	cai	d							
7	certificate nding phys	Med	IF FEMALE:							
A 30×	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Completed by Physician/Med	23b. Was decedent pregnant	f yes, outcome of pri □ Live birth 2 □	Fetal death 3 [Ectopic pregnancy	,		23d. Date of d Month	elivery Day Year
0.	the a	ysic	1 \(\text{Vos. 2 \(\text{No.} \)	I□Pregnant at time I□Unknown	of death 5	Other (specify)				
P	that the died by the detached	Ph	Part II. Other significent conditions contribu	uting to death, but no	t resulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
) -	uires tha signed Id be del	d b	Atrial P	hr///3	ton			1 🗆	Yes 2 1 № 3 □	Probably 4 Unknown
F	w requir s been s should	lete	Congestive	Hort	- FA 11	1111		24a. Was		autopsy findings available
Re	The lav ate has page 2	mo	The state of the s	V ((() V)	1			autor perfo	ormed?/ death	o completion of cause of es 2 No
ital	(Q C	Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only o		20110
7 E	Physicien: r this certifica ral director, i	To E	examiner? 1 Yes 2 No Hospi	ital: 1	2 ER/Outpatien	t 3 DOA	er: 4 Nursing H	lome 5 Resi	dence 6 Other (Sp	necify)
	ding Pl	on:	27. Manner of Death 21	Ba. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	Wor		28d. Describe	how injury occurred	
Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation		A15		Yes 2 □ No	004 1	Charles of Mark	3 10 11 11
AL/Division	I or Att after d Direct I in by	Certification:	4 Homicide determined	Be. Place of Injury - building, etc. (S)	pecify)	eet, factory, office		City or To	Street and Number or i wn, State)	Hurai Houte Number,
P	spite ours neral filled		29a. Certifier 1 Certifying Physicia	n: To the best of my	y knowledge, death	occurred at the fir	ne, date and place	, and due to the	cause(s) and manner	as stated.
.6	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medicel Examinar:							
	To th withir To th comp	M	29b. Signature and title of certifier	C	11 715	29c. Licens	e number	3	29d. Date signed (Mo.	nth, Day, Year)
	. 3		15arvara	ard	U, MIZ	J D	0 8 3 9 2	4	11291	2004
	10		30. Name and address of person who complete	eted cause of death	(Item 23a) (Type,	Print)	1/2 1	1 50 %	(9-1-	12.1.1111
			31. Date filed (Month, Day, Year)	32. Posistrar's 5	Signature /	, 15001	YORK	KD.	LOUKE	YSVILLE,
K	Sta Regist	ate rar	51. Date med (mc57, 547, 744)			artes		,		100

			1 - For State Registra MEND ITEM #2	State of	Marylan	d / Depa G83 BD. <i>Cei</i>	artment of	Health	and M	ental Hyg	jiene 1. 20	04	02944
			Decedent's Name (First, Middle, L.)							2. Date of Dea	th	Vana	3. Time of Death
	Physici		Robert Christ	tion Era	nkc					JANUA!	4y 25 21	Yeer Oo∂ ⊶	235 AM
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town	n, or Location	of Death		4c. County	of Death	
1			1734 C Founta:	in Rock V	Vay		Edge	ewood			Ha	rfor	đ
	Funeral		Social Security Number 6.		7. Age (In yrs.	•	If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthr	place (State or Foreign ntry)
	Director		094-28-8591	XXM 2□F	67	Yrs.				Apr. 30			York
	DO .		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	aryla aho	5				_	_						1 ☐ Yes 2√∑No
	79 N	ect	Maryland Hari	ford	l	Edgew	10f. Zip Cod	Δ		1.	10g. Citizen of V	What Cou	ntry?
	with	ä		n Dools Ms				1040			-	USA	,.
	death with the Maryland oms 23a or 28e-f ahow croust be notified at	Funeral Director	1734 C Fountair		dent Ever in U.	S. 13.1	Was Decedent	of Hispanic O	rigin? (Spe	cify Yes or No-			can Indian,
40	tter d	F	1 ☐ Never Married 2 ☑ Married	Armed Fo	rces? 2 ☐ No		If Yes, specify C	uban, Mexica	an, Puerto	Rican, etc.)	Blad	ck, White,	etc.
936	hours after tural', or Ite	by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	e		1⊡Yes 25x1	No Specify	y:		Specify	e B	1ack
5-0036	n 72 hours after death with the Marylan "natural", or flems 23a or 28e-1 show colcal Exp tuner coast be notified at	Completed	15. Decedent's (Specify only highest of	Education			dent's Usual Oc kind of work do		st of work	na	16b. Kind of Bu	usiness/In	dustry
21	within 7 ene. than "r	ald (Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use re	tired)		9			
21	filed withir Il Hygiene. other then	S	12			Main	tenance				Salvat		Army
nd	d oth	Be	17. Father's Name (First, Middle, La							(First, Middle,		10)	
<u>ya</u>	should be find Mental I	2		ranks					enora		(u/k)		
Maryland	0 0 0		19a. Informant's Name/Relationship				_			al Route Numbe lay, Edg			
_	s 1 and 3 if Health item 27 other tra		Sylvia Franks /	MTTG	20h P	1	osition (Name or			ate UNK			
0	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Quriel 2 ☐ Cremation 3		State AN	ATOMY B	na(off) dyffiner	place)		JIO U IOIC	BALTIMOR		
Ę	it. Pa intmer intent: injury		MXDonation 5 ☐ Other (Spe		Sal		Forest		#11• СТАТ	PE ANATOM	_		ls, Maryland
Baltimore	permit. Pages Department of t Importent: If ite any injury or of		A LOS I LIGHT	NALD S. WAI	DE, DIREC	DVR 1	317 Cok	esbury	Road	. Abino	don, Ma	LTO. S	AND ST. BALTO,MD nd 21 80 92120
			23a. Part1. Enter the disease, or co shock, or hear failure. List on	omplications that c nly one cause on e	aused the death ach line.	h. Do not ent	ter the mode of	dying, such a	is cardiac o	or respiratory ar	rest,	-	Approximate Interval Between Onset and Death
*	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	ncin	ono	- of	pan	non	2001			
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):	0						
п		-	Sequentially list conditions,	b	or as a conseq	uence of):						-	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
	be executed ician and burial-transit	Xar	that initiated events resulting in death) Last	c. Due to	or as a conseq	uence of):							
8760	ate be exec hysician an he burial-tr	cal		d									
687	tificate og phys as the	edlo	103										
Вох	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	M	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Je				23d. Da	te of deliv	ery
m	death a atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn	irth 2 Feta ant at time of d		∃Ectopic pregna ∃ Other (s <i>pecif</i> y				Mo	onth	Day Year
0	that the de ad by the detached	hys	9 Unknown	9□ Unkno	own								
٦,	res that signed b	by P	Part II. Other significant conditions	s contributing to de	eath but not res	ulting in the u	inderlying cause	given in Pari	t I.	23e. Did to	bacco use cont	ribute to t	the cause of death?
Ď	w require been sig should b		Lancison	a of	pros	late				1 🗆 Y	es 2□No	3 Prob	bably 4 Unknown
ပ္တ	s bee	plet		· /						24a. Was autop	an 24b.	Were auto	opsy findings available ompletion of cause of
ä	0 2 0	Completed								perfor	med?	death?	2√2 No
ta		BeC	25. Was case referred to medical					26. Pla	ce of Deat	Check only o			
of Vital Records,	dis dis	ToE	examiner? 1 X Yes 2 ☐ No	Hospital: 1 🔲	Inpatient 2	ER/Outpatie	nt 3 DOA	Other: 4 N	Nursing Ho	me 5 Resid	lence 6 🗆 Oth	er (Speci	fy)
0			27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date (Mon.	of Injury th, Day Year)	28b. Time o	f 28c. i	njury at Work?		28d. Describe h	ow injury occur	red	
<u>Ö</u>	Attending r death. ector: After by the fune	atle	2 ☐ Accident investiga	tion			М	1 ☐ Yes 2 [□No				
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289 Place	of Injury - At he ing, etc. (Specif		reet, factory, off	ice		28f. Location (S City or Tow		er or Rura	al Route Number,
	rs after all Dir												
	To the Hospital or Attent within 24 hours after deall To the Funeral Director: completely filled in by the	Medical		Physician: To the xaminer: On the b and man									
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Lic	ense numbe	r		29d. Date signe	d (Month,	Day, Year)
	-	1	Bernand	Yadina M	n. nmi		Doc	1420	6	1	- forman -	25.	260 4
			30. Name and address of person w	to completed caus	, .		Print)			I	1		
36			31. Date filed (Month, Day, Year)	/UKNA	legistrar's Signa		118 4021	ADIRA	AVE	BAL	70 md	212	.22
	St. Regist	ate rar	TED 0 4 2004	Band	Janes of the State	19 1	looner	#					

ORIGINAL

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 8 per fh G845 7-15-05 translate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** ELEANOR FERGUSON 2:10AM es ruty 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. la les 250 Subst 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 3-3-1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 202F Months 217-34-5 78 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any niqury or other traumatic event, the Madical Examiner must be multiled at once. 1 Yes 2 Mo md Director WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1250 5065 77 20601 1700 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Specify: White 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Communication lelephone perator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN ပ KNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Substation WALDORF MD 20601 ARGARET FAULKNER 12507 Baltimbre, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) trundel Creenty 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thonas alinau Keg15/47506 DC HANSON WS 71076 (3~ 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner lar dysease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner use as the burial-transit Due to (or as a consequence of): the attending physician P.O. Box 68 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to beath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? トとスケールSの ル ivision of Vital Records, Be Completed by 2 🖳 🗸 🔾 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificate 1 🗆 Yes 2 🗆 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Department 2 ER/Outpatient 3 DOA Medical Certification; To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. М investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide the Hospital 29a. Certifier Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7 State Registrar

31. Date filed (Month, Day, Year) 4 2004 EFR 0

re and add

tile of certifie

29b. Signature

of death (Item 23a) (Type, 10t) 32. Registrar's Signature

wratt

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** David Edward Fick February 2004 11:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2530 Windsor Road Parkville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year January 3, 1. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □X M 2 □ F 220-03-2519 85 Maryland Director Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☑ No Director Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 2530 Windsor Road 21234 USA Itama 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XDYes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 💢 No specifyhite Specify. 3 Nidowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Painter State 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental H Hem 27 is marked ot r othar traumatic ever Be Annie Schuman 2 Walter Fick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4694 Bucks School House Road Baltimore Maryland 21237 Sherry Lawrence/Niece 20b. Place of Disposition (Name of cemetery, crematory_or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot once. Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 2/6/04 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton Leonard J. Ruck, Inc. Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Hour /Medical Due to (or as a consequence of) Examiner Hun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physician and s the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physiclan/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Sesidence 6 Other (Specify) 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA this After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours are To the Funeral Dir To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 5601 Kan \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 4

			For	State of Maryland	d / Department of Health and	Mental Hygier	ne anni	0001-
			1 - State Registrar		Certificate of Death	Reg. I	No. ZUU4	U 2 9 4
	Physici /Medi		1. Decedent's Name (First, Middle, Las	ilyard		January		3. Time of Death A 3:25 M
	Examir	ner	48. Fecility Name (If not institution, give	rs Hospit	al Baltimor	-	4c. County of Death	
	Funeral Director		248-27-2060	7. Age (In yrs. la		8. Date of Birth	9 Birthple 917 South	ace (State or Foreign h) Carplina
	death with the Maryland oms 23a or 28a-f show Irmust be rollified at	tor	Usuel Residence of Decedent 10a. State 10b. County ATV and	10c. City,	Town or Location altimore	, ,	10	d. Inside City Limits
	with the	Il Direc	10e. Street and Number	anin St.	10f. Zip Code 21223	10g. (Citizen of What Countr	ry?
9	after death or Items 2 miner mu	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puè	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, et	
215-0036	within 72 hours after ene. then "natural", or Ite	eted by	3 Widowed 4 □ Divorced 15. Decedent's Ed (Specify only highest grad	year or Dates:	1 ☐ Yes 2 💆 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orkina 16b.	Specify: Black Kind of Business/Indu	ustry
2	filed within Hygiene. other then "		Elementary/Secondary (0-12)	College (1-4or 5+)	Sorter	R	ag Fac	tory
Maryland	nould be fi d Mental H narked ot natic ever	To Be	17. Father's Name (First, Middle, Last) Alexander	Roseboro	Rebe	me (First, Middle, Maidle)	tble	
-	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-1 show other traumatic event. If a Medical Examiner must be notified at		Mrs. Alimeter 20a. Method of Disposition	Irby 20b. Pla	19b. Mailing Address (Street and Number or R 325 N. Calhoun ace of Disposition (Name of	St. Ba	y or Town, State, Zip C Ho. Md., Location - City or Tow	21223
Baltimore	t. Page rtment c rtant: If njury or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Services License	Ne	metery, crematory or ether place) Wheel and 25 22. Name and Address of Facility	2004 B	alto. M	d.
Ba	Dermit. Departr Imports any inj		Joseph	L. Kuss	Joseph L. Russ Zzzzw. North As Do not enter the mode of dying, such as cardia	s Funeral re. Balto correspiratory arrest	Home Ma. Zizi	2 Approximate
	Physician /Medical	9,	shody, or heart faylure. List only of Immediate Cause (Final disease or condition resulting in death)		RESPIRATORY F	ALLURE		Approximate Interval Between Onset and Death
la/j-	Examiner	ıer	Sequentially list conditions if any, leading to immediate	b. ASTHM Due to (or as a conseque	A			
,092	te be executed ysician and ne burial-transit	cal Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseque	ance of):			
99	# × 6		IF FEMALE:	d				
P.O. Box	The law requires that the death certificate be existence as some signed by the attending physician bage 2 should be detached for use as the burian	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month D	y Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not result	ting in the underlying cause given in Part I.		o use contribute to the	
Records,	The law re ate has bee page 2 sho	Completed				24a. Was an autopsy performed?	prior to comp death?	sy findings available pletion of cause of
Vital	Physician: The Is this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	Other	ath (Check only one)		
of	Phy r this rald	n: To	27. Mann a of Death	1 Inpatient 2 VE	R/Outpatient 3 DOA Other: 4 Nursing H 28b. Time of lnjury at Work?	flome 5 Residence 28d. Describe how inj		
Division	ten leatl tor: the	Certification:	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M 1 Tes 2 No	28f. Location (Street a	and Number or Rural F	Route Number,
ō ₹	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Phy	sicien: To the best of my know	ledge death occurred at the time, date and place	and due to the cause	(c) and manner as stat	ed.
	To the Hi within 24 To the Fi complete	Medical	0/10/	and manner stated.	on and/or investigation, in my opinion, death occu			
	0	_	29b. Signature and title of certifier	and MD	D31993	29d. D	BRUARY 3	3, 2004
_	, }		30. Name and address of person who co	ompleted cause of death (Item 2		TIMORE S	T 212	223
	Sta Registr	- 7	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	TO COMPANY			

Gochour, Anna Marie Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

		State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death	lental Hygie		02948
		Decedent's Name (First, Middle, Last)	2. Date of Death	_	3. Time of Death
Physicia /Medic		ANNA M. GOCHNOUR	Month February	Day Year	4 4:44 pm
Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	
		Franklin Square Hospital Center Kosedale			more
Funeral Director		5. Social Security Number 212-16-9698 2 1 M 2 F F 22 Yrs. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) C	thplace (State or Foreign ountry)
		Usual Residence of Decedent	8/17/1921	I MA	RYLAND
ryland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Ba-fa	Director	MD BALTIMORE PARKVILLE			1 ☐ Yes 2 ☐ No
ath with the Marylan 23a or 28a-1 show lant by profiffed at	Dire	10e. Street and Number 10f. Zip Code	10g.	Citizen of What C	ountry?
hours after death with the Maryland turel; or frame 23s or 28s-f show all Examinating all	Funeral	110 HAPSBURG COURT 21234 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ocifu Ves or No-	USA 14. Race - Am	aricen Indian
fter d	Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Rican, etc.)	Black, Whi	
urs af	þ	3 ☐ Widowed 4 【MDivorced If Yes, Give 1 ☐ Yes 2 【No Specify: Year or Dates:		Specify: WH	ITE
hin 72 ho e. natur Medical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working the completed)	16b	. Kind of Business	/Industry
ithin ne. Mer	npl m	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		0	_
be filed within 72 tal Hygiene. d other then "nai		8TH GRADE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maid	OWN HOM	E
d be f antal h	o Be			en Sumame)	
should ind Men marke umatic	10	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	I AMICO I Route Number, Cit	ty or Town, State,	Zip Code)
and 2 sealth ar n 27 is			LTIMORE,		
is 1 a of Height		comptant cramatant or other place	ate 20c	Location - City or	Town, State
Pages nent of I int: If Its		AMBurial 2 Cremation 3 Hemoval from State	2004 PA	RKVILLE.	MD
permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If I flam 27 is marked other them any injury or other traumatic event, the MODE.		21. Signature of Funeral Service Licensee 22. Name and Address of FacilityTHE	JOHNSON F	UNERAL H	OME, P.A.
		8521 LOCH RAVEN BLV 23a Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of		N, MD 2	1286 Approximate
Dhysisian		shock, or heart failure. List only one fause on each line.			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) a. Deumonia Jue to (or as a consequence of):			
Examiner		SANTIA SHOOL			
T =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
acuter ind transi	Examiner	that initiated events c. CCTCTTTCC			
be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):			
phy the	dical	d			
The law requires that the death certification has been signed by the attending phoage 2 should be detached for use as to	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livery
atten	ciar	in the past 12 months?		Month	Day Year
that the de led by the detached	hysi	1 Yes 2 No 9 Unknown 9 Unknown			
res that igned to be deto	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
w require been sig should b	ed t		1 ☐ Yes	2 12 No 3 □ P	robably 4 Unknown
law re as be 2 sho	plet		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	Completed		performed	? death?	2 No
yaician: Th	Be (25. Was case referred to medical examiner? 26. Place of Death	(Check only one)		
. × × × v v	2		ne 5 Residence		city)
Attanding Phyaician: r death. ector: After this certific by the funeral director,	ilon	1 Ø Natural 5 ☐ Pending . (Month, Day Year) Injury Work?	28d. Describe how in	njury occurred	
uttand death ctor: y the	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street	and Number or R	ıral Route Number
s after s after la Dire	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town, St	ate)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
To the Hospital or Atlanding Ph within 24 hours after death. To the Funaral Director-After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of my control o	and due to the cause and at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of of tifler 29c. License number		Date signed (Mont	
A		> The RES ODDE	0	02/01/	04
5		30. Name and address of person who completed online of death (Item 23a) (Type, Print) Thandie Nyivenda 9000 Frankin Square [or Bait	more N	D 21237
Sta Registr	_	31. Date filed (Month, Day, Year) FEB 0 4 2004 32 Registrar's Signature			
	A 2	i Fo			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 29, **Physician** 8:40 P.M KATHERINE M. GREASER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7/29/1910 Birthplace (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 □XF Director 216-12-3591 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
It is marked other than "natural", or Items 23a or 28a-f ahow traumatic event, the Medical Examinational be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE TOWSON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 1506 COTTAGE LANE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 XWidowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 6TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maryland JESSIE MARSHALL DAISEY WOOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1562 PUITY HILL AVE. To Date TOWSON, MD 21286 WILLIAM G. LINS, JR. 20b. Place of Disposition (Name of cometery, crematory or other place)
DULANEY VALLEY MEM.
GARDENS 20c. Location - City or Town, State 20a. Method of Disposition 1 € Burial 2 □ Cremation 3 □ Removal from State 2/3/2004 TIMONIUM, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. MD 224 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bstructive disease months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Dlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, December 15,2004 1 Yes 2 No 3 Probably 4 Unknown post-operative pneumonia, renal failure congestive hear failure 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 TNo Vital 25. Was case referred to medical examiner?

1 Yes 2 No referred to medical to medical examiner?

1 Declined Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: Certification: To o 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) Division Fall at home, tripped in her Kitchen 1 Natural 5 Pending investigation of or Attendin after death. Director: Aft December 15,2004 1 ☐ Yes 2 X No 8:30PM 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 1506 Cottage Lane, Balto, MJ 21204 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 🗌 Suicide determined 4 Homicide filled in Home within 24 hours a To the Funeral C completely filled i 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 025205 January 30, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
W.A.R. Ley Game 6701 N. Charles St. Babto Md 21205 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 1,2004 **Physician** GRABOWSKI IRENE 4:50 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7332 GERMAN HILL ROAD DUNDALK BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yeer) 2/14/20 Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2□F 212-09-6850 83 Vrs Director MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director DUNDALK 1 Tyes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7332 GERMAN HILL ROAD 21222 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 StNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify 3 XWidowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 MACHINE OPERATOR AMERICAN CAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES SUDUBA HELEN SZYMANSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17222 19a. Informant's Name/Relationship (Type, Print) JOANNE L. HASSLER 6203 GREENBRIAR TERRACE FAYETTEVILLE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. HOLY ROSARY CEME. 2/5/04 * 4 ☐ Donation 5 ☐ Other (Specify) DUNDALK, MD. 21. Signature of Funeral Service Licensee KACZOROWSKI FUNERAL HOME P.A. ath 1201 DUNDALK AVE. BALTO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORO **Physician** /Medical Due to (or as a consequence of): Examiner Arterio Scherote 2 DiOS Arculisa Sequentially list conditions. Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit & THE RIMIN the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification; To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of ceptflier 29c. License number 29d. Date signed (Month, Dev. Year) D 24276 February 2,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2801 Hudson St. Balt., MD 21224 Simon V. Scalia, Dr. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 0 4 2004

			For State Registrar	State of Ma	ryland	•	rtment of H			ene 20	04	02951
	Dhuniai		1. Decedent's Name (First, Middle, La	•					2. Date of Death	1	Year	3. Time of Death
4	Physicia /Medic		WALDEN KELLE		JR.	•	4. Ch. T	Lassies of Death	·	1 200 4c. County of		4:40 a M
æ,	Examin	er	4a. Facility Name (If not institution, given 5430 SPRING				BALTI	Location of Death MORE		(NON)		
	Funeral		5. Social Security Number 6. S			st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		<u> </u>	place (State or Foreign
	Director	}	220-12-4648 Usual Residence of Decedent	AJM ZUF	80	Yrs.			07/13/1		1ARY	(LAND
	hours after death with the Maryland tural; or Items 23a or 28a-f show at Examiner must be notified at	Į.	10a. State 10b. County	NE)		Town or Loc					1	0d. Inside City Limits
	28a-f	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of W	hat Cour	
	th with		5430 SPRINGL	AKE WAY			2	1212		USA		
	er dea Items	Funerai	11. Marital Status	12. Was Decedent E		. 13. V	vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ , White,	can Indian, etc.
036	urs aft	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∰Yes 2 □ No If Yes, Give Year or Dates: W	WII	1	□Yes 21X No	Specify:		Specify:	WF	HITE
215-0036	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation		(Give I	ent's Usual Occupa	during most of work	king	16b. Kind of Bus	iness/In	dustry
12	d within 72 ho jiene. r then "natu ine Modical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	IIIe. L	ONOT use retired SING MA	"		OUSING	3 M <i>F</i>	ANAGEMENT
מַ	othe	Be Co	17. Father's Name (First, Middle, Last						e (First, Middle, M		-	
Maryland	Ment Ment arke	To	WALDEN GORSU						ETHEL C			
Mar	2 E S S		19a. Informant's Name/Relationship (EDITH GORSUC					and Number or Rui LAKE WA			-	
_	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Pla	ice of Dispos	sition (Name of satory or other place			Oc. Location - 0		
altimore,	Pages nent of ant: If it ary or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci			EENMO		l l	4/2004	BALTIN	10RF	MD.
Balt	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Lice	NNACO				ss of Facility HE				SONS CO,
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused to	the death.							Approximate Interval Between Onset and Death
ř	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				MULT	I FORE	(BRAIN -	(LAGHU)	1	5 MONTHS
b)	Examiner			Due to (or as a	conseque	ence of):						
,	P =	ner	sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a	conseque	ence of):						
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	conseque	ance of):					-	
8760,	e be e: /sician e buria	dical E		_ d								
9	ntificate I ng physi e as the t		IF FEMALE:									
Box	eath certifu attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti	E Fetal o	death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ery Day Year
o.	t the de by the a	nysic	1 Yes 2 No 9 Unknown	9□ Unknown		101 5	Other (specify)					
JS, P	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	Part II. Other significant conditions	contributing to death but	t not result	ting in the un	derlying cause give	en in Part I.	23e. Did tob	3/	bute to th	ne cause of death?
Records,	w requ been should	letec	NUIV						24a. Was ar	/\		psy findings available
	: The law cate has page 2:	Completed							autops) perform	r pr led? de	ior to cor ath? Yes	mpletion of cause of
Vita	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			3□ DOA Othe	ar.	th (Check only one			
	Phys or this oral dia	n: To	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of Injury	/ 2	R/Outpatient 28b. Time of	28c. Injun	at	ome 5 Resider			0
ion	Itending I Jeath. tor: After the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Year)	Injury	M 1	<br Yes 2 □ No				
Division of	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		ry - At hon . <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (Str City or Town,		r or Rura	I Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	edical Co	(Check only 2' Medical Exa	hysician: To the best of miner: On the basis of e	examinatio	rledge, death	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the ca	use(s) and man	ner as st	lated.
	o the lithin 2, o the l	Med	29b. Signature and title of certifier	and manner state	ed.		29c. License			ld. Date signed		
	⊢ ≯ ⊢ δ		1 / 9	Yar MA			10	040897		02/02/	•	
	V		30. Name and address of person who	mpleted cause of de	ath (Item :	23a) (Type, I						
			DONR MAN 31. Date filed (Month, Day, Year)	TN MJ	CO C'aisinna	, N.	CAMOLINIE	57.	BALIMO	ve, MI	, 21	297
	Sta Registi			0 4 2004	1 Sals	J. J.	Sperk	57.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State State Registrar AMEND ITEM #7 PER FH G828 2/04/04 J@ertificate of Death 2. Date of Death **Physician** /Medical Examiner ocation of Death If Under 24 Hrs. rs. last birthday) If Under 1 Year **Funeral** Director Usual Residence of Decedent the Maryland City, Town of Location 10d. Inside City Limits 23a or 28e-f show the Medical Examiner must be notified at Funeral Director 1 Yes 2 No 10e. Stree and Number 10g. Citizen of What Countil/ Was Decedent Ever in U.S. Armed Forces? or Itema 11. Marital Status 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americary Indian, Black, White, etc. filed within 72 hours after 2 100 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ive kind of work done during a DO NOT use retired condary (0-12) other than College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liquy or other traumatic event 2008. Be Alationship Method of Disposition ☐ Burial 2 ☐ Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice see 23a. Pan 1. Eyler the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 13 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial Records, P.O. Box 68760. Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Day signed by the a 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Dnknown should t 1 Yes 2 No 3 Probably certificete has the 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed? res 20/No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 Yes 2 No the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) e bruans 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 0 Loch Balli

State Registrar 31. Date filed (Month, Day, Year) 32. I

32. Registrar's Signature

			1 - For State Registrar	State of	Marylar		artment			nd M	ental Hyg	iene	200	4 02953
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Helen Margaret	Grayt	eal						2. Date of Dea Month January	Day	Yee 2004	M
4	Examir		4a. Facility Name (If not institution, give 4013 Ridgecroft Ro	street and num			Ва	1tim			odiidar y		County of De	
	Funeral Director		5. Social Security Number 6. Security Number 1 S	M 2 🛛 F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day) Oct. 6,	Year) 1928		Birthplace (State or Foreign Country) St Virginia
	Maryland -f ahow	tor	10a. State 10b. County Maryland		10c. Ci	ty, Town or Lo		Balt	imore	!			<u>.</u>	10d. Inside City Limits 1√2 Yes 2 □ No
	th with the 23a or 28e	ai Director	10e. Street and Number 4013 Ridgecroft Ro	ad	\		10f. Zip		21206		1	-	en of What	Country?
036	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28e-f ahow the Medical Examiner must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? No	4	Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		4. Race - Ar Black, W Specify:wh	
21215-0036	l within liene. r than "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		4or 5+)	life.	dent's Usua kind of wor DO NOT us TVISO	k done d e retired,	lu <i>rina</i> most	of workir	9	16b. Kin	d of Busines	ss/Industry
Maryland 2	be filed ital Hyg id other avant,	To Be C	17. Father's Name (First, Middle, Last) Lloyd L. Walker	0 :)					Ne1	lie	(First, Middle, M			
	nd 2 :		19a. Informant's Name/Relationship (Ty Sue Reisinger-Daug		1	4013	Ridge	crof		d Ba	Route Number 1timore	, Ma	rylan	d 21206
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)				Wash	.Cre	mator	y 2/	4/2004	Laur	e1, M	•
Ball	permit. Page Department Important: It any injury o		21. Signature of Funeral Service License	258		6	415 B	elai	r Roa	d Ba	ler-Dip ltimore	, Ma		
A	Physician /Medical Examiner		23a. Part). Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	. C	r as a conseq	uence of):		of dying	g, such as c	ardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
8760,	ate be executed sysicien and he burial-transit	Ical Examiner	Sequentially list conditions, any beauty to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		r as a conseq		1630							
.O. Box 6	that the death certifica ed by the attending ph detached for use as tt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 ☐ Fete nt at time of d	Ideath 3	Ectopic pre					23	3d. Date of d Month	lelivery Day Year
rds, P	နှင့် မို	by	Part II. Other significant conditions cor	stributing to dea	ith but not res	ulting in the ur	nderlying ca	use give	n in Part I.			acco us		to the cause of death? Probably 4 □Unknown
tal Records,	The law ate has b page 2 s	e Completed	25. Was case referred to medical								24a. Was as autops perform	ned2	prior to death?	autopsy findings available ocompletion of cause of 9
Division of Vital	ding Phys h. After this funeral di	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1		ER/Outpatien 28b. Time of Injury		c. injury Work	r: 4 🗆 Nurs	sing Hom	(Check only only e 5 ☐ Reside 3d. Describe ho	nce 6		HOSPICE
Divis	- 9	Certification:	3 Suicide 6 Could not be determined	building	g, etc. (Specif						City or Town	, State)		Rural Route Number,
	To the Hospitel o within 24 hours aft To the Funerel Discompletely filled in	edical	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medicel Exemination (Check only one)	sician: To the b ner: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred a restigation,	t the time in my op	e, date and inion, death	place, ai occurre	nd due to the ca d at the time, da	use(s) a ite and p	nd manner a lace, and di	as stated. ue to the cause(s)
•		W	29b. Signature and title of certifler		MD	20.V.T	1	License) C C	number	181		-11	na la	nth, Day, Year)
	90	to	30. Name and address of person who co	Dser-	Bock Signa	eng	Y Y	120	(an	op b	eu c	5/40	Bul	1 h more 19d 2123.
	Sta Registr	-	FEB 0 4 2004		war de	A A	ales.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02954 1- For State Registra AMEND ITEM 19a PER FH G828 2/04/04 Gentificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 7:459 M 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimor Merci at If Under 1 Months 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 F South Carolina Director Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If Item 27 is marked other than "natural", or Items 23s or 28s-1 show or other traumatic event, its Medical Examinal must be notified at 1 Yes 2 No Maryland
10e. Street and Number Directo more 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: 3 Widowed 4 □ Divorced lac 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental ဥ Informant's Name/Relationship (Type, Print) (Father) 19b. Mailing Address (Street and Number or Rural Route Number, City State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 Is. any injury or other trausones. BROTHER 2 504 Ho.Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Joseph L. Ru
2222 W. North Funeral Balto. 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALCINOM **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed? Yes 2 No 2 2 No 1 Yes 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) WOS DICC Hospital: 1 Yes 2 No Medical Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cephiler 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

FEB 04

20

Marc 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

		For State Registrar			nd / Depa		Health and M		giene 200	4 0295
		Decedent's Name (First, Middle	e, Last)					2. Date of D	eath	3. Time of Death
Physici		Mildred			Harr	ic		Month 7	31 O4	9.55 PM
/Medic Examir		4a. Facility Name (If not institution	n, give street and num	ber)	Harr		or Location of Death		4c. County of De	
		Future Care N	.н.			Balt	timore		NA	
Funeral		5. Social Security Number		. Age (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Bi (Month, D		irthplece (State or Foreign
Director		217-36-4679	1□M 2 (□F	82	Yrs.	Months Days	Hours Min.	8-21-		Va.
pu ,		Usual Residence of Decedent		10: 0"					4.	
death with the Maryland ms 23a or 28a-f show Errival Le notified at	-	10a. State 10b. County		10c. Cit	ty, Town or Lo					10d. Inside City Limits
Ba-f	cto	Md.	NA AV		Baltin	nore				12 Yes 2 □ No
or 2	E S	10e. Street and Number				10f. Zip Code			10g. Citizen of What (Country?
15 w 23 m	al	1823 N. Aisqu	ith Street			212	202		USA	
r death with tems 23a or kr maat be	Funeral Director	11. Marital Status	12. Was Deced Armed Ford	lent Ever in U	.S. 13.	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or Ni	14. Race - An Black, Wh	
o ====		1 Never Married 2 Mar	ried 1 ☐ Yes 2	XNo		1 ☐ Yes 2 🎇 No		Thous, Blo.,		iite, etc.
72 hours natural;	d by	3 XWidowed 4 □ Divorced	Year or Dat	tes:		· C · C · C · C	, орвску.		Specify:	Black
2 2 2	ete	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Deced	dent's Usual Occu	ipation a during most of work ad)	tina	16b. Kind of Busines	s/Industry
within ene. then	ld I	Elementary/Secondary (0-12)	College (1-4	4or 5+)	1		ed)			
filed wit Hygien other tha	Completed	8th grade 17. Father's Name (First, Middle,			Do	mestic			Other Peo	ple Homes
be filed tal Hygi d other	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle	, Maiden Surname)	
should by and Menta	ု	Joseph		Stephe	ens		Mary	L	ucy B	randon
2 2 2 2		19a. Informant's Name/Relations Juanita Davis	hip <i>(Type, Print)</i> Daughter	2					er, City or Town, State, .imore, Md.	Zip Code) 21213
Demit. Pages 1 and Jepartment of Health mportant: If Item 27 nny injury or other tr		20a. Method of Disposition		20b. P		sition (Name of natory or other pla		Date	20c. Location - City of	
		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from St	IAIO				0.4		
permit. Page Department of Important: If Iny injury or Ince.		21. Signature of Funeral Service		Gar		Forest V			Owings Mi	
Depa Depa Impo eny i		21. Signature of Funeral Service	Licensee	.)		2. Name and Addre			timore, Md	
40244		23a. Part1. Enter the disease, or	pwa	ريما		larch F.			E. North Av	re.
Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	r as a consequence of the conseq	uence of):		nenti		esse	Onset and Death
icate be executed physician and sthe burial-transit	cal	resulting in death) Last	Due to (or	as a consequ	uence of);					
certificat Iding physee as th	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna	ncv				2015	
The law requires that the death certification has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birt	h 2 ☐ Fetal nt at time of de	Ideath 3	Ectopic pregnanc Other (specify) _	y		23d. Date of de Month	Day Year
res that th signed by t	by PI	Part II. Other significant condition	ons contributing to deal	th but not resu	ulting in the un	nderlying cause giv	ven in Part I.	23e. Did t	obacco use contribute (o the cause of death?
uire n sig	Q D							10	Yes 2□No 3□P	robably 4 Dunknown
w require	Completed									
he law requires t e has been signe sge 2 should be o	E D							24a. Was autop		utopsy findings available completion of cause of
									a No 1 ☐ Ye	s 2 10
hysician: The law his certificate has t I director, page 2 s	Be	25. Was case referred to medical examiner?				100	26. Place of Death	Check only o	ne)	
Physician: this certific	P.	1 ☐ Yes 212 No	Hospital: 1 🗆 Inp		ER/Outpatient	3 DOA		me 5 🗆 Resid	dence 6 Other (Spe	ecify)
	on:	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Injui Wor	ry at rk?	28d. Describe I	now injury occurred	
Attending Ph ir death. ector: Atter th by the funeral	atl	2 ☐ Accident investig	ation				Yes 2□No			
er de recte	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 28e. Place of	Injury - At ho	me, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number or R	ural Route Number,
tators aft	Cer			, ()	,			Ony or 101	m, state)	
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the be Examiner: On the basi and manner	is or examinat	wledge, death ion and/or inv	occurred at the tirestigation, in my c	me, date and place, opinion, death occurr	and due to the ed at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
o th	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
P ≯ P Ö) leagat No	2	Λ	1-D				2/2/	
2	-	NOVIA				104	1405		41104	
0		20. Name and address of person of LIAQAT A	who completed cause of L 1 821		23a) (Type, I	St. /	Betenne	MD	2/20/	
Sta		31. Date filed (Month, Day, Year)	No.	istrar's Signat						
Registra	ar	FEB 0	4 2004	Pallage .	12 1	Escath 1				

DHMH 17 Rev 1/2001

ORIGINAL

		•	1 - For State Registrar	State of M	laryland / Depa <i>Cei</i>	artment of H			ene . No. 2004	029	56
			1. Decedent's Name (First, Middle, Last,					2. Date of Death	_	3. Time of De	ath
Н	Physicia		Mary	Elizabet	h	Havran		January	29, 2004	1:30	P^{M}
	/Medic Examin		4a. Facility Name (If not institution, give	street and number	•)	4b. City, Town, or	Location of Death		4c. County of Deeth		
	Examin	٠.	7431 School Avenue			Dundalk			Baltimore	9	
	Funeral		Social Security Number 6. Security Number	(ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		plece (State or Fo	oreign
	Director		214-26-2922]M 2 ∑ F	74 Yrs.	Months Days	Hours Min.	May 15,1	929 MI		
	D		Usual Residence of Decedent		140 00 7						
	show thow	_	10a. State 10b. County	_	10c. City, Town or Lo	_				10d. Inside City L 1 ☐ Yes 2)	
	Ba-f	cto	Md Baltimor	e	Dunda	TK	<u> </u>				Ž140
	or 2	Dire	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?	
	ath w	La La	7431 School Avenue			2122			USA		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	?]No	Was Decedent of Hi f Yes, specify Cubai 1 □ Yes 2\(\frac{1}{2}\)No	spanic Origin? (Spe n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.	
Õ	2 ho	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occupa	ation	16	b. Kind of Business/I	ndustry	
2	thin 7	Completed	(Specify only highest grad	College (1-4o	· 5+)	DO NOT use retired,	furing most of workir)	'g			
7	gien gien er th	Con	12 years		Н	ousewife			Own Home		
9	al Hygid I other vent, II	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Me	iden Sumame)		
/a	should be ind Mental marked o umatic eve	10	John Allen				Mary Do	nlin			
an	2 sho and is ma	1	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	Route Number, C	City or Town, State, Zi	p Code)	
	and and a salth n 27		Mary Theresa Havra	n Daugh	The state of the s		Avenue, D	-			
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 ti eny injury or other tra ance.		20a. Method of Disposition 1 Burial 2XXCremation 3 DF	lamoval from State	20b. Place of Dispo	sition (Name of natory or other place	e) Febru	ate 20	c. Location - City or T	own, State	
Ĕ	Pages nent of ant: If it ury or o		*4 □Donation 5 □ Other (Specify)			Crematory	·		altimore C	ity, MD.	
at	permit. Departr Importe eny inju		21. Signature of Funeral Service Licens	99	6	Name and Addres	uneral Ho	me Of Du	ndalk,P.A.		
0	89 E 29		,	V	7	110 Solle	rs Point	Road, Du	ndalk.MD.	21222	
>	Physician /Medical		23a. Pert1. Enter the disease, or compl shock, or heart failure. List only of timmediate Cause (Final disease or condition resulting in death)	ne cause on each	ed the death. Do not ent line.	er the mode of dying		r respiratory arrest		Approximate Intervat Betwee Onset and Dea	
A	Examiner	}	1	Due to (or a	s a consequence of):	,	4				
		_	Sequentially list conditions,	Due to (or a	s a consequence of):						
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	222 10 (0. 2	3 4 3 5 1 6 5 7 7						
	cale be executed physician and the burial-transit	xar	that initiated events resulting in death) Last	Due to (or a	s a consequence of):						
8760,	be e ician buria	alE									
687	icate phys s the	dical		1			<u> </u>				
.O. Box (The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetat death 3	Ectopic pregnancy Other (specify)			23d. Date of delin Month	rery Day Yea	r
۵.	res that t igned by be deta	/ Ph	Part II. Other significant conditions co.	ntributing to death	but not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of deat	h?
ords	requires been sign should be	eted by							2 □ No 3 Pro		
Vital Records,		Completed						24a. Was an autopsy performe	prior to co	opsy findings ava ompletion of caus 2000 No	e of
<u> </u>	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:	ac	Othe	26. Place of Death	The Real Property lies			
	Phys this al di	1°	1 Yes 2 SNo	1 🔲 Inpai		I JU DOA	4 Nursing Hon	ne 5 X esidence 8d. Describe how	e 6 Other (Speci	fy)	_
L C	ding l h. After funer	lon	1 Matural 5 ☐ Pending	28a. Date of In (Month, D	ay Yeer) tnjury	Work	(? Yes 2 □ No	od. Describe now	injury occurred		
<u>s</u>	death. death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of I	njury - At home, farm, str			18f Location (Street	et and Number or Rui	al Poute Number	
Division of	or Attendated after death Director:	Certification:	4 Homicide determined	building,	atc. (Specify)	eet, ractory, office		City or Town,	State)	ai nodie ivanibei,	,
_	Hospital or Attending 24 hours after death. Funeral Director: Afte tely filled in by the fune		29a. Certifier 1 Certifying Phy	sician: To the hes	t of my knowledge, death	a occurred at the tim	ne date and place a	nd due to the cour	co(s) and manner as	ntatad	
8	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exami	ner: On the basis and manner	or examination and/or in	estigation, in my op	pinion, death occurre	ed at the time, date	and place, and due	to the cause(s)	
`	To the within 2 To the comple	Me	29b. Signature and title of certifier	Λ		29c. License	number	29d	. Date signed (Month,	Dey, Year)	
	C>F0		K/wlike	2 all ms	19Th	DOM	15/77/	5	muaru 30	3 200	4
	O1		30. Name and address of person who co	ompleted cause of	death (Item 23a) (Type, Oorleans strar's Signatuse	Print)	11111	,	1		
	1		Julie R. Brahmer,	MD 1105	O Orleans	Stroot P	Sa Lt-True A	Mariela	10 212	3/	
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signature	1	· · · · · · · · · · · · · · · · · · ·	, 07 910	714 2/9		
	Registr		FEB 0 4 2004	Acres an	15 A	oarks/					

		Registrar Unpend Item#23a, 1. Decedent's Name (First, Middle, Last)	/	11.	.)	2. Date of Death Month	Day Year	3. Time of Deat
Physici /Media		\sim	IOSES	HARV	'IN	JANUARY	27,2004	6:17P.
Examir		4a. Facility Name (If not institution, give street	et and number)		4b. City, Town, or Location of De	ath	4c. County of Death	1
		JOHNS HOPKINS BAYVIE	W MEDICAL	CENTER	BALTIMORE			
Funeral Director		5. Social Security Number 6. Sex 10 M Usual Residence of Decedent	7. Age (In)	rs. last birthday) Yrs.	Months Days Hours Mi		9. Birth Cou	nplace (State or For Intry) CARDU
Marytand -f show lind at	5	10a. State 10b. County	10c.	City, Town or Loc				10d. Inside City Lin
affer death with the Marylan or items 23a or 28a-f show inther roughte notified at	Funeral Director	10e. Street and Number		DACI	IMORE 10f. Zip Code	, 10g	. Citizen of What Cou	untry?
death with the ms 23a or 28a r rust be noti	eral	1014 KINGSWA	Was Decedent Ever in	D in U.S. 13. W	Z1Z18 Vas Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Amer	
	by	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pui Yes 2 No Specify:	erto Rican, etc.)	Black, White	LACK
" na	Completed	15. Decedent's Education (Specify only highest grade co	ompleted)	(Give I	ent's Usual Occupation kind of work done during most of w DO NOT use retired)	rorking 16	b. Kind of Business/I	ndustry
il Hygiene. Il Hygiene. other then	Comp		College (1-4or 5+)	0 -	BLE TECHNIC		VERI	ZON
s 1 and 2 should be filed withing Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event even	To Be	17. Father's Name (First, Middle, Last) TOHN E. A	HARVIN			ame (First, Middle, Ma.)	IAE BI	LLIE
nd 2 sh alth and 27 is m ir traum		19a. Informant's Name/Relationship (Type, CHERYL HARVIN)	WIFE	19b. Mailing	g Address (Street and Number or . KINGS WIV ROP	Rural Route Number, C HD BAITT		
0 = 5		20a. Method of Disposition 1 M Burial 2 Cremation 3 Remo		b. Place of Dispos cemetery, crem		Date 20d	c. Location - City or T	own, State
ntmer rtent rtent njury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee	0 60	ARRISON 1	TOREST 2. Name and Address of Facility V	-707 DU	VINGS MIL	S MITTEY (
Depa Impo any i		1/antes	Greene	4	905 YORK ROM	AVAILY C. C.	MORE, MI	21212
hysician		disease or condition	ions that caused the dause on each line. lications of	Transfor			Injection	
/Medical Examiner	al Examiner	shock, or heart failure. List only one c Immediate Cause (Final	ause on each line.	Transford sequence of):	-aminal		Injection	Interval Between
Medical be executed to entiticate be executed with the state of the prial-transit of the pria	cal	shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ause on each line. Lications of Due to (or as a con:	Transfor Transfor Sequence of): sequence of): sequence of):	-aminal		Injection 23d. Date of delive Month	Interval Betweer Onset and Deat
Se first the death certificate be executed The standard of th	cal	shock, or heart failure. List only one collection of the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions contrib	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	Transfor Transfor sequence of): sequence of): sequence of): sequence of): organicy Fetal death of death 5	aminal The Cervical Epidur Ectopic pregnancy Other (specify)	al Nerve Root	23d. Date of delive Month	interval Betweer Onset and Death
aw requires that the death certificate be executed to be supported by the attending physician and a should be detached for use as the burial-transit	cal	shock, or heart failure. List only one collection in the past 12 months? If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 \sum No 9 \sum Unknown	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	Transfor Transfor sequence of): sequence of): sequence of): sequence of): organicy Fetal death of death 5	aminal The Cervical Epidur Ectopic pregnancy Other (specify)	23a. Did tobac 1 Yes	23d. Date of delive Month co use contribute to 2 No 3 Pro	rery Day Year the cause of death
aw requires that the death certificate be executed to be supported by the attending physician and a should be detached for use as the burial-transit	Completed by Physician/Medical	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions contrib Cervical Spondylosis C4-	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	Transfor Transfor sequence of): sequence of): sequence of): sequence of): organicy Fetal death of death 5	aminal The Cervical Epidur Ectopic pregnancy Other (specify)	23e. Did tobac	23d. Date of delive Month co use contribute to the contribute to	rery Day Year the cause of death bably 4 AUnknopsy findings avail
aw requires that the death certificate be executed to be supported by the attending physician and a should be detached for use as the burial-transit	Be Completed by Physician/Medical	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1 Ukive birth 2 Pregnant at time of Unknown outing to death but not	Transfor Transfor Sequence of): sequence of): sequence of): sequence of): resulting in the un	Ectopic pregnancy Other (specify) derlying cause given in Part !.	23e. Did tobac 1 Yes 24a. Was an autopsy performed 1 Yes 2 U	23d. Date of delive Month co use contribute to the contribute to	interval Betweer Onset and Death Part of the cause of death bably 4 Munkmings availability opsy findings availability on cause 2 No
aw requires that the death certificate be executed to be supported by the attending physician and a should be detached for use as the burial-transit	To Be Completed by Physician/Medical	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1 Ukive birth 2 Pregnant at time of Unknown outing to death but not	Transfor Transfor Sequence of): sequence of): sequence of): sequence of): resulting in the un sequence of the control of	Ectopic pregnancy Other (specify) derlying cause given in Part !. 26. Place of D 3 □ DOA Other: 4 □ Nursing	23e. Did tobac 1	23d. Date of delive Month co use contribute to the 2 No 3 Property of the Contribute 17 No 1 X Yes e 6 Other (Special Property 1 X Yes)	interval Betweer Onset and Death Part of the cause of death bably 4 Munkmings availability opsy findings availability on cause 2 No
aw requires that the death certificate be executed to be supported by the attending physician and a should be detached for use as the burial-transit	To Be Completed by Physician/Medical	shock, or heart failure. List only one collemediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contrib Cervical Spondylosis C/F-C	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1	Transfor Transfor Sequence of): sequence of): sequence of): sequence of): sequence of): resulting in the un sequence of): 28b. Time of injury	Ectopic pregnancy Other (specify) derlying cause given in Part I. 26. Place of D 3 □ DOA Other: 28c. Injury 4 □ Nursing 28c. Injury 4 □ Nursing	23e. Did tobac 1 Yes 24a. Was an autopsy 1 Yes 2 eath Check only one) Home 5 Residence 28d. Describe how	23d. Date of delive Month co use contribute to a 2 No 3 Pro 24b. Were authorized to death? 1 X Yes 6 Other (Special injury occurred)	interval Betweer Onset and Death Onset and Death Death Death Day Year the cause of death bably 4 Munkmings availability oppsy findings availability of cause 2 No
aw requires that the death certificate be executed to be supported by the attending physician and a should be detached for use as the burial-transit	To Be Completed by Physician/Medical	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1 Live birth 2 Fegnant at time of Unknown Duting to death but not 28a. Date of Injury (Month, Day Year 1/6/04	Transfor Transfor Sequence of): seq	Ectopic pregnancy Other (specify) derlying cause given in Part 1. 26. Place of D 3 □ DOA Other: 4 □ Nursing 28c. Injury at Work? 1 □ Yes 2010 No	23e. Did tobace 1 Yes 24a. Was an autopsy performer 1 Yes 24a. Yes 2 Oestribe how in complication	23d. Date of delive Month co use contribute to the 2 No 3 Pro 24b. Were authorisor to condeath? 1 No 1 X Yes e 6 Other (Special injury occurred insert of the capture)	interval Between Onset and Death Park The cause of death bably 4 AUnknot Opsy findings availability on process and Death Park The Cause 2 No
aw requires that the death certificate be executed to be supported by the attending physician and a should be detached for use as the burial-transit	To Be Completed by Physician/Medical	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 1 Unknown Due to (or as a con: If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 1 Dunknown Duting to death but not 1 Time of 1 Tim	Transfor Transfor Sequence of): seq	Ectopic pregnancy Other (specify) derlying cause given in Part 1. 26. Place of D 3 □ DOA Other: 4 □ Nursing 28c. Injury at Work? 1 □ Yes 2010 No	23e. Did tobac 1	23d. Date of delive Month co use contribute to a 2 No 3 Pro 24b. Were authorized to death? 1 X Yes e 6 Other (Special Propertion occurred in the contribute or Runtate)	Interval Betweer Onset and Death Death Death Death Death Death Death Death Death Death Death D
aw requires that the death certificate be executed to be supported by the attending physician and a should be detached for use as the burial-transit	To Be Completed by Physician/Medical	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contrib Cervical Spondylosis C/F-C 25. Was case referred to medical examiner? 1 Yes 2 No Hosp 27. Manner of Death	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1	Transfor Transfor Sequence of): seq	Ectopic pregnancy Other (specify) derlying cause given in Part 1. 26. Place of D 3 □ DOA Other: 4 □ Nursing 28c. Injury at Work? 1 □ Yes 2010 No	23e. Did tobac 1 Yes 24a. Was an autopsy performed. 1 Yes 2 General Check only one) Home 5 Residence. 28d. Describe how complication. 28f. Location (Stree City or Town, S. 3901 Greens	23d. Date of delive Month co use contribute to the contribute to	interval Betweer Onset and Death Very Pay Year the cause of death bably 4 AUnknoopsy findings availompletion of cause 2 No
aw requires that the death certificate be executed to be supported by the attending physician and a should be detached for use as the burial-transit	Be Completed by Physician/Medical	shock, or heart failure. List only one collemediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1 Live birth 2 Pregnant at time of pulling to death but not C5 Dital: 1 Mapatient 2 28a. Date of Injury A building, etc. (Spetim Management and The Best of Injury and The Best of Injur	Transfor Transfor Sequence of): seq	Ectopic pregnancy Other (specify) derlying cause given in Part I. 26. Place of D 3 DOA Other: 4 Nursing 28c. Injury at Work? 1 Yes 20100 et, factory, office	23e. Did tobace 1 Yes 24a. Was an autopsy performed to the control of the contr	23d. Date of delive Month co use contribute to the contribute to	interval Between Onset and Death Onset and Dea
requires that the death certificate be executed The seen signed by the attending physician and thould be detached for use as the burial-transit	To Be Completed by Physician/Medical	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contrib Cervical Spondylosis C/F-C 25. Was case referred to medical examiner? 1 Yes 2 No No Hosp 27. Manner of Death 1 Natural 5 Pending investigation 1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Medical Examinar: (Check only one) 1 Certifying Physicia (Check	Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: Due to (or as a con: If yes, outcome of pre 1 Live birth 2 Fegnant at time of 9 Unknown Due to (or as a con: If yes, outcome of pre 1 Live birth 2 Fegnant at time of 9 Unknown Due to (or as a con: If yes, outcome of pre 1 Live birth 2 Fegnant at time of 9 Unknown Due to (or as a con: If yes, outcome of pre 1 Live birth 2 Fegnant at time of 9 Unknown Due to (or as a con: If yes, outcome of pre 1 Live birth 2 Fegnant at time of 9 Unknown Due to (or as a con: If yes, outcome of pre 1 Live birth 2 Fegnant at time of 9 Unknown Due to (or as a con: If yes, outcome of pre 1 Live birth 2 Fegnant at time of 1 Live birth 2 Fegnant at time of 1 Live birth 2 Fegnant at time of 1 Live birth 2 Fegnant at time of 1 Live birth 2 Fegnant at time of 1 Live birth 2 Fegnant at time of 1 Live birth 2 Fegnant at time of 1 Live birth 2 Fegnant at time of 1 Live birth 2 Fegnant at time of 1 Live birth 2 Fegnant at time of 1 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 2 Live birth 2 Fegnant at time of 3 Live birth 2 Fegnant at time of 3 Live birth 2 Fegnant at time of 3 Live birth 2 Fegnant at time of 3 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth 2 Fegnant at time of 4 Live birth	Transfor Transfor Sequence of): seq	Ectopic pregnancy Other (specify) derlying cause given in Part 1. 26. Place of D 3 □ DOA Other: 4 □ Nursing 28c. Injury at Work? 1 □ Yes 20 No et, lactory, office occurred at the time, date and plae estigation, in my opinion, death oc	23e. Did tobac 1 Yes 24a. Was an autopsy performed. 1 Yes 2 Geath Check only one) Home 5 Residence 28d. Describe how complication 28f. Location (Stree City or Town, S) 3901 Greens ce, and due to the caus curred at the time, date	23d. Date of delive Month co use contribute to the contribute to	interval Between Onset and Death Onset and Death

			1 - For State Registrar AMFND ITFM #10	State of Maryl	and / Dep		Health and	Mental Hy		200	4 02958
	Physici /Medi		1. Decedent's Name (First, Middle, Last	HOL	der	and the second		2. Date of Dea Month	ath Day		
	Examir Funeral	ner	4a. Facility Name (If not institution, give Harbor Hos.) 5. Social Security Number 6. Se	spital Co	enter yrs. last birthday	Balt	or Location of Dea	s. 8. Date of Birt	th	County of Dea	
	Director		296-10-9626 Usual Residence of Decedent 10a. State 10b. County	OM 2□F 9.		Months Days	Hours Min	. (Month, Day	v. Year)	910 Roi	
	the Maryla 28e-f shorn	Funeral Director	Maryland Baltimor		altimor				10a. Citi	izen of What C	10d. Inside City Limits 1 ☐ Yes 2 📉 No
	th with	a DI	CHANTILIA 2122 Chintilly Ro	ad		21228			-	ed Sta	
036	be filed within 72 hours after death with the Maryland lal Hygiene. dother than "naturel", or items 23a or 28e-f show event, the Mudical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	n U.S. 13.	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No		Specify Yes or No- rto Rican, etc.)		14. Race - Am Black, Whi	
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	(e completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retire	during most of wo d)	orking		ind of Business	,
	filed v Hygie other t		17. Father's Name (First, Middle, Last)	4	Elec	rical Eng		me (First, Middle,			ontracting
Maryland	should be nd Mental marked o	To Be	Juliu Holder 19a. Informant's Name/Relationship (Ty	vpe. Print)	19b Mail	ing Address (Street	Emili	a Ioanov:	ici		Zin Codo)
	nd 2 salth ar 27 ls		John R. Solomon/So			Contenti					
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other traumatic 20028.		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	200 Removal from State	 Place of Disp cemetery, cre 	osition (Name of or other place) S Cemeter	ce) Febr	Date cuary 5	20c. Lo	cation - City or	
Balt	permit. Departr Importe any inju		21. Sign uneral Service Literal	MO(0803 B	2. Name and Addre ethesda-C ethesda.	ess of Facility Ro hevy Cha Marvland	bert A. se, Inc. 20814-1	Pump 755 3501	ohrev F	uneral Home onsin Avenue
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complished, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	eath. Do not en	nter the mode of dyli	ng, such as cardia	c or respiratory arr	rest,	-	Approximate Interval Between Onset and Death 2 Weeks
1760,	ate be executed hysician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infriated events resulting in death) Last	Due to (or as a cons CORON O Due to (or as a cons	sequence of):	,	Dis	canci			1 year
687	ificate g phys			1912	10/131	0/1					1 4 5 011
.O. Box	Attending Physician: The law requires that the death certifica creatile. Croadla. Sector: Agine this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the sector.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	☐Ectopic pregnanc; ☐ Other (specify) _	у		2	23d. Date of de Month	livery Day Year
ords, P	equires that en signed b ould be deta		Part II. Other significant conditions con First begree	A	resulting in the u	underlying cause giv	ven in Part I.	1	bacco us	_	o the cause of death?
Vital Record	: The law ri cate has be page 2 sh	Completed by						24a. Was a autops perfori	sy	prior to death?	utopsy findings available completion of cause of
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner?	lospital:		ot 3 DOA Oth		ath (Check only on			
o	y Phyr ar this aral di	To To	1 ☐ Yes 2 📉 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie 28b. Time o	III JU DON	4 🗆 Nuising F	ome 5 Reside			cify)
ion	ath. rr: Afte	atio	1 Accident 5 Pending investigation	(Month, Day Year) Injury	Wor			,,,,,		
Division of	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (St City or Town	reet and n, State)	d Number or Ru	ural Route Number,
	To the Hospitel or within 24 hours afte within 24 hours afte To the Funeral Dir. completely filled in it.	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	th occurred at the tin estigation, in my o	me, date and place pinion, death occu	e, and due to the carred at the time, d	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)
•	~	∑ .	29b. Signature and title of certifier	M. M.D		RE S	e number	F	9d. Date	signed (Month	h, Day, Year) 02,2004
	10		30. Name and address of person who co	BOR, 300,		Print) ANOVER	ST, Bo	timor	e,	MD	02,2004
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra Sig	gnature	Angel.					

			For State Registrar	State	of Maryl		artment of F				jiene ,	2004	02	959
			Decedent's Name (First, Middle	, Last)						2. Date of Dea	th		3. Time	of Death
	Physicia			Rebecca (Christi	ine Harm	on			Month Januar	Day V 28.	Year 2004	2:17	РМ М
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location	of Death		*	ounty of Death		
	Xdiiiii	•	Holy Cro	oss Hospi	ital		Si1	ver :	Sprin	Q		Montg	omerv	
	Funeral		5. Social Security Number	6. Sex		yrs. last birthday)	If Under 1 Year Months Days		r 24 Hrs.	8. Date of Birth (Month, Day	Year)	9. Birth		e or Foreign
	Director		220-58-9061	1 □ M 2 📉 F	5:	2 Yrs.	Mortus Days	riours	IVIII.	July 13		_	Mary]	Land
	2	- [Usual Residence of Decedent		140-	Oit To the						т		
	death with the Maryland ms 23a or 28a-f show rmust be rivilitied at	_	10a. State 10b. County		100	. City, Town or Lo	cation						10d. Inside	es 2 🕅 No
	Ba-f a	cto		ntgomery			1	ensin	gton					15 Z X 140
	or 2	Director	10e. Street and Number				10f. Zip Code				l0g. Citizer	n of What Cou	ntry?	
	ath w		3555	Raymoor				208				Inited		s
	toma from	Funerai	11. Marital Status	Armed F			Was Decedent of H If Yes, specify Cuba	lispanic Oi an, Mexica	rigin? (Spe in, Puerto f	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,		
9	or t	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, G	2 X No Sive		1 ☐ Yes 2 ሺ No	Specify	<i>'</i> :		Sp	ecify:		
Š	hour tural		15. Decedent	Year or	Dates:	152 Dogg	dent's Usual Occup	ation			16h Kind	of Business/Ir	White	
<u>ה</u>	n 72 nai	Completed	(Specify only highes	it grade completed	d)	/Give	kind of work done	durina mo:	st of workir	ng			,	
7	withii ene. than	Ĕ	Elementary/Secondary (0-12)	College	(1-4or 5+)	Techno	ology Man		ent G	roup	Cent	ers fo dicaid	r Med	icare
7 5	Hygid ther ant, I		17. Father's Name (First, Middle,		+	Direc	cor	18. Moth	ner's Name	(First, Middle,			Serv.	rces_
מום	d be ental	o Be	Poher	t Spauldi	ing Har	rmon				Managa	D-14	a		
5	marl matt	ပ	19a. Informant's Name/Relations		ing nai		ng Address (Street	and Numb	er or Rura		Poli	-	n Code)	
Z Z	id 2 s ith ar 27 is trau		Constance E. Cra		on End									
n,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be nultified at once.		20a. Method of Disposition	iig/raiti		b. Place of Dispo	sition (Name of			ate		tion - City or T		
2	ages ont of t: If it		1 ☐ Burial 2 🏻 Cremation 4 ☐ Donation 5 ☐ Other (S)		1 4.2	lontgomer	natory or other plac Y	ce)	Janua 30,	ary,		. 1	3.5	.1 1
altimor	artme ortan njury		21. Signature of Furferal Service		10	remator		ss of Facil				thesda		
O O	permi Depar Impo any ir	, ,		Y	/ 100	B B	2. Name and Addre	hevy	Chas	e Inc	7557	Wisco	nsin .	Avenue
	- y		23a. Part 1. Enter the disease, or shock, or heart failure. List	omplications that		00335 B	ethesda, er the mode of dvin	Mary. ng. such as	s cardiac o	r respiratory arr	OU1 est.		Approxim	ate
			shock, or heart failure. List Immediate Cause (Final										Interval B Onset and	
	Physician /Medical		disease or condition resulting in death)			11monary	Arrest							
	Examiner													
Ц		e_	Sequentially list conditions,			Cancer								
	June d	듣	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•										
,	exect n and lal-tra	Examiner	resulting in death) Last	C. Due to	o (or as a con	isequence of);								
20	w requires that the death carificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	dlcail		d								Ī		
00	ificat g phy as the	0	-											
×	nding use	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pre		Ter				230	I. Date of deliv	ery	
Ď	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 💹 No	4□Preg	birth 2 1 I gnant at time]Ectopic pregnancy] Other (specify)	/ 				Month	Day	Year
2	t the	hys	9 Unknown	9LJ Unk	nown									
L	The law requires that the ate has been signed by the page 2 should be detache	by P	Part II. Other significant condition	ns contributing to	death but not	resulting in the u	nderlying cause giv	en in Part	1.	23e. Did to	bacco use	contribute to t	he cause of	death?
cords	quire n sig uld b									1 🗆 Y	es 2 🗆 N	lo 3□Prol	babiy 4 🛭	∬Unknown
	s bee	Completed								24a. Was a	n 2	4b. Were auto	opsy finding	s available
n L	sician: The law s certificate has t irector, page 2 s	E								autops	ned?	death?		cause of
VII G		O	25. Was case referred to medical					26 Plac	e of Death	1 ☐ Yes (Check only or	2 No	1 🗆 Yes	2 L NO	
	Physician: this certific al director,	0	examiner? 1 ☐ Yes 2 🔯 No	Hospital:	√Inpatient	2 ER/Outpatier	nt 3 DOA Oth	00		ne 5 Resid		Other (Specia	6v)	
ō	9 Phys er this eral di	L.	27. Manner of Death	28a. Date	e of Injury onth, Day Yea		28c. Injur	y at		8d. Describe h			37	
5	nding tth. :: Afte	tio	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig	9	nin, Day rea	ir) Injury	Wor M 1 □	k? Yes 2.[]No					
DIVISION	il or Attending Patter death. Director: After t	ifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 288. Plac	ce of Injury - /	At home, farm, str	eet, factory, office		2	8f. Location (S	reet and N	lumber or Rura	al Route Nu	mber,
5	s afte	Certification:	4 Nomicos	Juli	ding, etc. (Sp	оспу)				City or Town	i, State)			
,	pspit hours inara y fille	<u>e</u>	29a. Certifier 1 X Certifyin	g Physician: To th	he best of my	knowledge, deat	occurred at the tin	ne, date a	nd place, a	nd due to the c	ause(s) an	d manner as s	tated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	edic	(Check only 2 Medical one)	and ma	basis of exam	mination and/or in	vestigation, in my o	pinion, de	ath occurre	o at the time, d	ate and pla	ace, and due to	o the cause	(s)
_	To tl withi To tl comp	ž	29b. Signature and title of certifier	10			29c. Licens		_	2	9d. Date s	igned (Month,	Day, Year)	
-	/		Paul Me	a Kou	(47	-61	2		11	2810	Y	
	25		30. Name and address of person	who completed ca	use of death	(Item 23a) (Type,	Print)							
	5		Paul MacKoul, N				enue #414	Betl	nesda	, Maryl	and 2	0814		
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's		1 1 0							
	Registr	ar	FF	B 0 4 200	7 60	الكو استانكا	AST 28486	18						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MKY MAMTE HOLMES 204 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S 7. Age (In yrs. last birthday) 96 yrs If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 137-30-5672 Director 18 1907 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show Examiner must be nutified at 1 Yes 2 No Director PRINCE GEORGE'S LANHAM 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or items 23a 8200 GOOD LUCK RD 20706 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK þ 3 □ Widowed 4 □ Divorced "natural", t other than "natura ivent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOME MAKER 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 90ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leslie Hall Lette Ha11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADRIAN HAMEED 2934 BUCKTHORN COURT GLENARDEN, MARYLAND /NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 1-24-04 CLINTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reumonia **Physician** day /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Box 68760. as IF FEMALE esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Day Year 5 Other (specify) ed by the a detached f P.O. 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed) page certificate 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only To the ! 29b. Signature and title of certifuer 29c. License number 29d. Date signed (Month, Day, Year) 04 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20704 mo Sty world 7404 31. Date filed (Month, Day, Year) 32. Redistrar's Signature 0 4 2004 PARTER. Registrar

				1 - For State Registrar	State of Ma	ryland /		rtment of tificate of	Health and M Death		giene Reg. No.	004	0296
		Physici /Medic		Doris DORIS ELLEN 1. Decedent's Name (First, Middle, L.) DORIS ELLEN	est) HANNAH	S				2. Date of De Month	Day	Year ZOO	3. Time of Death
	ار -	Examir Funeral Director			of Baltim	o (In yrs. last i	birthday) . Yrs.	4b. City, Town, Baltiv If Under 1 Year Months Days	r If Under 24 Hrs.	8 Date of Bir VMonth, Da June 5	th ly, Year)	Cou	place (State or Foreign
		pu 🏃		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation		Journe 5	, 1,555_		10d. Inside City Limits
		death with the Maryland ms 23s or 28s-f show Friust be multing at	tor	Maryland Harfo	ord		Bel	Air					1 ☐ Yes 2 ☑ No
		ih the or 28s	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of		
		a 23a	ral	1404 D Bonnett	Place	tues in II S	12.14		.015	poits Vas or No	14 00	US ice - Ameri	
. 4	980	72 hours after deal natural, or itame i	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Tes 2X N If Yes, Give Year or Dates:			Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	Rican, etc.)	Speci	ack, White,	
Hannalus	Maryland 21215-0036	- 100	Be Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)	ducation		(Give I	ent's Usual Occu kind of work done OO NOT use retire	e during most of work	ing	16b. Kind of I		
X	1212	filed within Hygiene.	Com	17. Father's Name (First, Middle, Las	2	*/	Home	emaker	18. Mother's Nam	a /First Middle		Home	
The	lanc	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, the Mi	To Be	Louis Herman					Emma	Agnes		 Shiel	.ds
	lary	2 shou and N is man aumal	[·	19a. Informant's Name/Relationship	. • .	1			at and Number or Rur				
5		as 1 and 2 of Health item 27 i		Kenneth R. Hannal	ıs – Husban		_		ett Place,	Bel Ai	r, Mary		21015
Dovis	100	Pages hent of		20a. Method of Disposition 1				sition (Name of atory or other plane) Memoria		0/04			Maryland
7	Baltimore,	permit. Pages Department of Important: If it any injury or once.	3	21. Signature of Funeral Service Live	-	Tinging to	22.	Name and Addr	ress of Facility MC	Comas F	uneral	Home,	P.A.
3				23a. Part1. Enter the disease, or cor shock, or heart-failure. List on	nplications that caused	the death. D			Broadway, I			and	21014 Approximate Interval Between
3		Physician /Medical		snock, or neart-tallure. List one Immediate Cause (Final disease or condition resulting in death)	a. Simal	1+10	ryge	1	el obst				Onset and Death
tient lenow	68760,	icate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. OVUY Due to (or as: Due to (or as:	consequence	Ceurse of):	ncer					2 movilus
Pat	Box	Attending Physician: The law requires that the death certificat releath. actor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 250 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnand Other (specify)	су			ate of deliver	ery Day Year
	S, D	res that igned b	þ	Part II. Other significant conditions				derlying cause g	iven in Part I.	23e. Did t			he cause of death?
	Record	ne law requir nhas been si ge 2 should	Completed	deep venous	Modish	- 108es				24a. Was	an 24b.	Were auto	posy findings available impletion of cause of
	ta	ysician: The is certificate hadinector, page	Be Co	25. Was case referred to medical					26. Place of Deat	1 Yes	2 No	1 🗆 Yes	2/No
	Division of Vital Records, P.O.	uttending Physici death. ctor: After this cer y the funeral direc	ို	examiner? 1 Yes 2 No 27. Manner of Death 1 Vatural 5 Pending 2 Accident investigate	Hospital: 1 Inpatie 28a. Pate of Injur (Month, Day	y 28t	Outpatient o. Time of Injury	28c. Inju	ther: 4 🗆 Nursing Ho		dence 6 □Ot		(y)
	Divis	al or Atte s after de if Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			farm, stre	et, factory, office	9	28f. Location (. City or Tox	Street and Num vn, State)	ber or Run	al Route Number,
K		To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical ((Check only Z Medicel Exa	hysician: To the best of miner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the estigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and m date and place	anner as s , and due to	tated. o the cause(s)
4		To the To the Company	5	29b. Signature and title of certifier	0 110			29c. Licer	ise number		29d. Date sign		
		J		30. Na a and a ress of person who	completed cause of de	eath (Item 23a	a) (Type, f	Print)	3-000	(Janua	y 2	7,2004
		Sta	oto	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Sin	a Hos	pital of 1	SWITW	we		
		Regist		EED 0 4 2004	Beneva	19	A CO	acker			1		

		•	For State Registrar	State of Mar		artment of H tificate of L			ene 200	4 02962
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic	_	DORIS			HESS		FEBRUARY	1, 2004	11:45 A M
	Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, or			4c. County of De	
;			5400 VANTAGE POIN 5. Social Security Number 6. Sex)5 In yrs. last birthday)	If Under 1 Year	COLUMB If Under 24 Hrs.	8 Date of Birth	9.8	HOWARD
	Funeral Director			M 20 F	86 Yrs.	Months Days	Hours Min.	MAR. 24,1	917	Country) MD
	ס	,	Usual Residence of Decedent							· · · · · · · · · · · · · · · · · · ·
	anylan show	_	10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits
	289-f	ecto	MD HOWAR	עו	COLU	JMBIA 10f. Zip Code		100	g. Citizen of What (1 Tes 2 No
	with	Funeral Director	5400 VANTAGE POIN	IT ROAD #60	15	TOI. ZIP GOGG	21044	,	g. Onizon of Times	U.S.A.
	ms 2	nera		12. Was Decedent Eve		Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No-		nerican Indian,
920	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It filem 27 is marked other than "natural", or flems 23a or 28e-f ehow if it other traumatic event, it is Meulical Exam and the molified at	þ	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 Yes, specify Cuba 1 ☐ Yes 2 💢 No	Specify:	o Hican, etc.)	Specify:	WHITE
21215-0036	72 ho	Completed	15. Decedent's Edu		16a. Dece	ient's Usual Occupa	ation during most of wor	king	6b. Kind of Busines	s/Industry
121	ne. han	mpj	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired [CE_MANAG])		MENS' CL	OTHING
В	be filed v ntal Hygie od other t		17. Father's Name (First, Middle, Last)		0773	CE MANAGI		ne (First, Middle, Ma		UINING
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Its Me	To Be	LOUIS			.MUTH	SARA			BUXBAUM
Mar	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationship (Ty) SUSAN FRANKEL / DA	NUGHTER				OLUMBIA,		, ZIP Code)
	t and Health tem 27 other tr		20a. Method of Disposition	OUTTER	20b. Place of Dispo	sition (Name of			Oc. Location - City	or Town, State
<u>o</u> E	Peges nent of int: If It		1 M Burial 2 ☐ Cremation 3 ☐ R * 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	BALTIMORE	natory or other plac HFRRFW (· 1	/2004	BALTI	MORE, MD
Baltimore,	permit. Peges 1 an Department of Heal Importent: If Item 2 eny injury or other ance.		21. Signature of Funeral Service License	91/	The second secon	. Name and Addres		OL LEVINS		
<u> </u>	89 = 8		Edward C. A	m		3900 REIS		ROAD - P		, MD 21208
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line.	e death. Do not ent	er the mode of dying	g, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Metasta	ric Lung	Cance				10 mouth
20	/Medical Examiner		1	Due to (or as a	consequence of):					
	70	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequence of):					
	cuted id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	e exection ar		resulting in death) Last	Due to (or as a c	consequence of):					
8760,	icate be executed physician and s the burial-transit	dicai		l						
9	death certificate be executed e attending physician and id for use as the burial-transit	/Me	IF FEMALE:	3c. If yes, outcome of	pregnancy				23d. Date of d	lelivery
Вох	death atten	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No	1 Live birth 2 4 Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
P.O.		hys	9 Unknown	9□ Unknown					}	
Ś	se se	by	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause give	en in Part I.			to the cause of death? Probably 4 Dunknown
CO	> 12 0	ompleted						24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
H.	0 - 5	mo						performe	ed? death	es 2 No
/ita	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	7 7.				ath (Check only one)		0.000
of V	ys dis	မ	1 ☐ Yes 2 ☑ No		2 ER/Outpatier		4 Itursing F		ce 6 ☐Other (S _I	pecify)
uo.	ding h. After funer	tion	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	/eer) 28b. Time o	Work	yat k? Yes 2 □No	28d. Describe how	virijury occurred	
Division of Vital Record	l or Attending latter death. Director: After In by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)			28f. Location (Stre City or Town,		Rural Route Number,
٥	urs af urs af srel D		00 0 47 - 47 - D							
	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 G Certifying Physical Check only 2 Medical Examione)	sician: To the best of ner: On the basis of ea and manner state	xamination and/or in	vestigation, in my of	pinion, death occu	irred at the time, dat	e and place, and d	ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1 12 11	11	29c. License			d. Date signed (Mo	_
	\sim		1 / Michilas la	- Noutre l	www sons	Dian)	8509	<i>F</i>	e bours	, 2, 2004
	10		30. Name and address of person who co	INTO A list	(1065 /	I HE PA	TUXCIT	Prylokin	ubin m	D 21044
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	s Signature		-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1		
	Registr	ar	FFR 0 4 2004	Dasser.	s Signature					

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	rtment	of Health are of Death	nd Me		ene 200	4 02963
			Decedent's Name (First, Middle, Last)				2	. Date of Death		3. Time of Death
	Physici	_	Robert	Han	p for			1	Month	Day Yea	1 1 1 n 1 1 1
>	/Medio		4a. Fecility Name (If not institution, give	street and number)	700	4b. City, 1	own, or Location of		-	4c. County of De	
	Examili	ei		CAEST BIU	D		4AG-0251			WASHIN	1-ton
	Funeral			x 7. Age (In yrs		If Under	1 Year If Under 24	4 Hrs. g	Date of Birth		lirthplace (State or Foreign Country)
	Director		579-40-9877 10	2M 2□F 7		Months	Days Hours	Min.	(Month, Day, Y WGH H	1933 WA	SHINGON DIC.
	D		Usuel Residence of Decedent								
	how		10a. State 10b. County		ity, Town or Lo						10d. Inside City Limits
	e Ma	5	mo 2174	1	14A64	RS TO	OWN				1 ☐ Yes 2 ☑ No
	문 8 2 등	Director	10e. Street and Number			10f. Zip	Code		10g	. Citizen of What	•
	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28a-f ehow ta Medical Ezana'ne mulu Le rolliliad at	ai	20433 KING	CREST B	(01)		2174	7		U.S.,	4,
	r de	Funerai	11, Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decede Yes, spec	ent of Hispanic Origin Ty Cuban, Mexican, I	n? (Specif Puerto Ric	y Yes or No- can, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
9	or II	by Fu	1 Never Married 2 Married	1 ∐ Yes 2 ☑ No If Yes, Give	1	☐ Yes 2	TNo Specify:			Specify: /	Shite
ğ	ural',		3 Widowed 4 Divorced	Year or Dates:	1 10 5						
21215-0036	net net	Completed	15. Decedent's Edu (Specify only highest grad		(Give	ent's Usua: kind of worl OO NOT us	Occupation k done during most of a retired)	of working	16	b. Kind of Busines	ss/Industry
12	within	ğ.	Elementary/Secondary (0-12)	College (1-4or 5+)	1110. 2		NEMA	111		UTIZII	TY
2	Hygie ther	ပိ	17. Father's Name (First, Middle, Last)						First, Middle, Ma		
aŭ	d be	80		AMPTON			Tu	1:1	m 20	-1001	
Ž	d Me d Me mark matic	은	19a. Informant's Name/Relationship (T	/	19h Mailin	o Address	(Street and Number	or Bural F			Zin Code)
Maryland	d 2 s th an trau		Robert HAMP			•				•	PS Tom MP 2174
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 le marked other than "netural", or Items 23e or 28a-f ehow appringury or other traumatic event, the Medical Enditing must be indiffied at Once.		20a. Method of Disposition	20b.	Place of Dispos	sition (Nam	e of	Date		c. Location - City	
Baltimore,	ages nt of t: # it		1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	cemetery, cren	atory or other	her place)	/			
틀	rtani njun	1	 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Ligent 	I We	57 /-//	Name and	Crewity Fo	suy "	1, duy	outur	
Ba	Department of the perturbation of the perturba			1					77/10	li 00 11	411 10 20121
			23a. Parti, Ar heart failure. Jiet only o	nomo(_)	th. Do not ente	er the mode	of dying such as ca	ardiac de o	espiratory arrest	signe 14.	Approximate
			shock or heart failure. List only of Immediate Cause (Final	ino cause on each mie.					oophatory arrost	1	Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. No ~ - D	bds kin	's L	y my hon	~			3 years
	Examiner			Due to (or as a conse	quence of):						
Engle .		_	Sequentially list conditions,	b. Due to (or as a conse	ouenee off:						
	ted nsit	nin	if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events		.,.						
•	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):						
8760,	be e siciar buris										
687	icate phys	dicai		a							
×	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancy					23d. Date of d	leliven
Вох	atter for u	ciar	in the past 12 months?	1☐Live birth 2☐Fet 4☐Pregnant at time of	el death 3 🗌	Ectopic pre				Month	Day Year
o.	that the de ed by the detached	iysi	1 Yes 2 No	9□ Unknown							
<u>α</u>	res that the signed by be detact	P.	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	derlying ca	use given in Part I.		23e. Did tobac	co use contribute	to the cause of death?
ds	uires sign ld be	q p							1 🗌 Yes	2 No 3	Probably 4 Unknown
Ö	w requir been si should I	Completed							24a. Was an	24h Were	autoney findings available
Re	The lav	m D						-	autopsy	prior to	autopsy findings available o completion of cause of ?
a			05.11/						1□ Yes 2E	No 1□Ye	es 2 No
⋚	Physician: r this certificanal director,	Be c	25. Was case referred to medical examiner?	Hospital:	7500	-7.00	Other		Check only one)		
ō	Phys r this ral dir	- T	1 ☐ Yes 2 ☑ No 27. Menner of Death		ER/Outpatient 28b. Time of		Bc. Injury at		5 Residence Describe how	e 6 □Other (Sp	pecify)
G	ding P. After fune	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No		3. 50001100 11011	mijary oddanod	
Division of Vital Records,	or Attending after death. Director: After in by the fune	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - At I	nome farm stre				Location (Stree	at and Number or	Rural Route Number,
5	after Direct In by	erti	4 Homicide determined	building, etc. (Spec	ity)	, , , , , , , , , , , , , , , , , , , ,			City or Town, S		10000 10000,
	Hospital 24 hours a Funeral I		29a. Certifier 1 7 Certifying Phy	/sician: To the best of my kn	owledge, death	occurred a	it the time, date and	place, and	d due to the caus	se(s) and manner	as stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Exam	iner: On the basis of examin and manner stated.	ation and/or inv	estigation,	in my opinion, death	occurred	at the time, date	and place, and di	ue to the cause(s)
	To the within 2 To the comple	₹	29b. Signature and title of certifier			29c.	License number		29d	. Date signed (Mo	nth, Day, Year)
	- s - o		Dandhun A	mh.			04166)		2.1.	04
	10		30. Name and address of person who c	ompleted cause of death /Ite	m 23a) (Type	Deint)					,
	り				1/1/0	Med	real Car	. 1	Bene	hour 1	10 21742
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign		made 3	, out car	mos	11- 15/1	,	
	Registi		FEB 0 4 20	104 Jest Com.	10. 18						

			1 - For State Registrar	State	of Marylar		artment of rtificate o				giene 2 (004	02961
	Physici /Medi	_	1. Decedent's Name (First, Middle Edwar L	1		VAM	ES		2	Date of Dea Month	Day	Year 2004	3. Time of Death
	Examir Funeral		4a. Facility Name (If not institution Future Care 5. Social Security Number			. last birthday)	Reist	erstow ar If Under	7 n 24 Hrs. 8	. Date of Birt	h	imor	
v	Director		223-34-2476 Usual Residence of Decedent	1 ⊠ M 2□F	79	Yrs.	Months Da	ys Hours	Min.	(Month, Day 08 2	5 24	N	lace (State or Foreign try) C
	the Marylar 28a-f show	Director	10a. State 10b. County MD Carr 10e. Street and Number	011		nksbui		A			10g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 No
9	hours after death with the Maryland turel', or Items 23s or 28s-f show all Exercises from the cutified at	Funeral	3007 Cornett 11. Marital Status 1 □ Never Married 227 Marri	12. Was Dec Amed F	cedent Ever in U orces? 2 \(\sum \text{No} \) ive		Was Decedent of Yes, specify C	21048 of Hispanic Original Mexican	gin? (Speci		U .	S.A.	an Indian,
Maryland 21215-0036	in 72 n nal	Completed by	3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed,	Dates:	16a. Dece (Give life.	1 ☐ Yes 2 ☐ 1 dent's Usual Occ kind of work do DO NOT use rel	cupation	t of working		Specification 16b. Kind of B	usiness/Ind	lustry
yland 21	d be filed ental Hyg ced othe c event,	To Be Cor	10th grade 17. Father's Name (First, Middle, I Linwood Jame				Baker_			First, Middle,	Dunki Maiden Suman		nuts
iore, Mar	es 1 and 2 shi of Health and f Item 27 Is m ir other traum		19a. Informant's Name/Relationsh Stephanie Was 20a. Method of Disposition 1 ▼Burial 2 □ Cremation	hington.	State 20b.	ter 30 Place of Dispo cometery, cres	sition (Name of natory or other ;	cnett	Driv Dat	e, Fi	nksbur 20c. Location	g M City or Tov	d 21048 wn, State
Baltimore,	permit. Pag Department Importent: I eny inlury o		*4 □Donation 5 □Other (Sc. 21. Signature of Funeral Service)	icensee Maril	_	M = 4.	Name and Ada arch F, 300 Wal	dress of Facility H Wes Dash A	t ve,	Balti	more M		11s, Md
8760,	Physician /Medical Examiner physician and physician and the printing t	dical Examiner	23d. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	(or as a consection as a consection of the conse	quence of):	DE	yng, such as a	cardiac or r	espiratory arr	est,		Approximate Intervat Between Onset and Death
.O. Box 68	ne death certific the attending p thed for use as	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregn birth 2 Feta nant at time of a	al death 3	Ectopic pregnal Other (specify)					te of deliver	y Day Year
٥	signed be de	b	Part II. Other significant conditio	ns contributing to c	leath but not res	sulting in the u	nderlying cause	given in Part I.		23e. Did to			e cause of death?
of Vital Records,	The law ate has b page 2 s	e Completed	25. Was case referred to medical								med? 2.X.No	prior to com death?	sy findings available pletion of cause of
ion of Vil	ing Phys n. After this funeral dir	ToB	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date (Mor		ER/Outpatien 28b. Time of Injury	28c. In	Other: 4 Nur	rsing Home		ne) ence 6 ⊡Oth ow injury occurr		
Division	or At fter d jiraci in by	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 200. Place	of Injury - At h ing, etc. (Speci	ome, farm, str	eet, factory, offic	Se Se	281	. Location (St City or Town	reet and Numb n, State)	er or Rural	Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	fedical	one)	Physician: To the Examiner: On the band man	best of my kno asis of examina iner stated.	owledge, death ation and/or inv	occurred at the restigation, in m	time, date and y opinion, deatl	i place, and h occurred	due to the ca at the time, d	ause(s) and ma ate and place,	inner as sta and due to t	ted. the cause(s)
)	2 1 2 5	W	29b. Signature and title of certifier 30. Name and address of person v	yho completed cau	se of death (tren	TI 23a) (Tune	1 A	158	72	1 1	9d. Date signed		ay, Year) 2009 36
	Sta	te	31. Date filed (Morth, Day, Year)	BORG	20 :	25 M	Min s	thers	Re	Jer	tong	211	36
	Registr	ar	LCDOS	4.3	Alland M	A SECOND	ALL!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. C. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY ROBERT LEWIS JACOBSON 2004 6:02 PM 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number)
Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 1/19/33 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) NEW YORK 1⊠M 2□F 126-32-5548 65 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No BALTIMORE TOWSON MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code APT. 506 21286 302 E. JOPPA RD. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 S No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry NEW YORK CITY Elementary/Secondary (0-12) College (1-4or 5+) HEALTH & HOSP. HOSPITAL ADMINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE M. JACOBSON STELLA GERSTENZANG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGUERITE JACOBSON /WIFE BO2 E. JOPPA RD. APT. 506 TOWSON, MD. 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State BAYVIEW CREMATORY 2/3/04 BALTIMORE, MD. 1 4 ☐ Donation 5 ☐ Other (Specify) KACZOROWSKI FUNERAL HOME P.A. 21222 21. Signature of Funeral Service Dicensee (aut _ _ 1201 DUNDALK AVE. BALTO., MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPHALOPATHY WEEK Due to (or as a consequence of) CARDIAC ARREST 1 WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): FOREIGN BODY AIRWAY OBSTRUCTION WEEK Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 02-01-04 D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND M. D. FRANCIS KHOO.

State

31. Date filed (Month, Day, Year) FEB 0 4 2004



ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Physician

/Medical

Examiner

Funeral

Director

or than "naturel", or items 23a or 28e-f ehow the Medical Exeminer must be notified at

al Hygiene.

h and Mental I

item 27

permit. Pege Department of Importent: If eny injury or once.

Physician /Medical

Examiner

burial-tran

use as the

been signed by the should be detached

page

the funeral director.

filled in by

npletely

death.

within 24 hours after deat To the Funerel Director:

nding physicien

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Peges 1 ö <u>=</u>

other treumetic event.

Funeral Director

Completed by

Be

Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

death with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			1 - For State Registrar Unpend Item#2 1. Decedent's Name (First, Middle, Las		828,3/4/06	etificate of	Death	2. Date of Deat			0 2 9 6 6 3. Time of Death
	Physici /Medi		RONALD	JA	CKSON			JÄNÜARY	z 24, 20) 0°4	11:25 AM
	Examir		4a. Facility Name (If not institution, give PRINCE GEORGES H		ΓER		r Location of Death		4c. County		ORGES CO
	Funeral Director		5. Social Security Number 6. S 215-70-9682 1 Usual Residence of Decedent	9x 17. Age (In 17. Age (In 17. Age (In	yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 4 27	Year) 1957	9. Birthp Coun Den	lace (State or Foreign try) ver Co.
	low low		10a. State 10b. County	10	c. City, Town or L	ocation				1	0d. Inside City Limits
	with the Maryland or 28s-1 show	ctor	MD Prince G	eorge's		Hyattsv	ille				1∭Yes 2☐No
	vith th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W		try?
	ns 23e	Funeral	3421 55th Aven	ue # 203 12. Was Decedent Ever	in U.S. 13	Was Decedent of H	lisnanic Origin? (Spec	of v Yes or No-	U.S.A		an Indian,
030	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show acel Ester divertional be notified at	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No E If Yes, Give Year or Dates:	Army	If Yes, specify Cubs 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spec an, Mexican, Puerto F Specity:	Rican, etc.)		c, White,	
21215-0036	72 hours 'natural', dicel Exe	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup	ation during most of workin	1	16b. Kind of Bu	siness/Inc	lustry
7		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired ndy-Man	d)	3	Privat		
ט פ	filed Hygid other ent,	a)	17. Father's Name (First, Middle, Last)		lla.	ndy-rian	18. Mother's Name	(First, Middle, M			
/lar	uld be Wenta Irked Iric ev	ToB	Timonthy Jack	son			Lorice	Johnson	L		
, maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. MODE.		19a. Informant's Name/Relationship (7 Lorice Oates/Moth	er			and Number or Rural k Rd # 5 I	Route Number, annam,	City or Town, S Mary Lar	id 20	968
Baitimore,	ges 1 t of He Miten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	nemovarmom State		osition (Name of matory or other place	i i	1.5	Oc. Location - 0	•	
	it. Pa urtmen urtant: njury njury		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen			e Cremato 2. Name and Addres	ory 1-30-	04 Ri B. Jenl	iverdal		
Da	Depa Impo any in		A. D. Ha	shall		7474 Lar	dover Roa	d Landov	ver, Ma		
	Physician /Medical Examiner	er.	23a. Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions.	Due to (or as a col	nsequence of):	static pulm	onary adenoc.	arcinoma	31,		Approximate Interval Between Onset and Death
	xecuted and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor						4	
68/60,	tificate be executed ig physician and as the burial-transit	ledical E		d							
.O. Box	death cer e attendir d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont		y Day Year
ras, r	The law requires that the ate has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions of	ntributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	II.			e cause of death?
II Kecords,		Completed						24a. Was an autopsy performe	ed? pr	or to com	sy findings available apletion of cause of
VIII	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Cthe	26. Place of Death (
5	ਦੂ ≑ ਛ	. To	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day Yea	ER/Outpatier 28b. Time of	I 3LI DOA	4 Nursing Home	e 5 Residen			
<u>-</u>	Attending F r death. sctor: After by the funer	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	r) Injury	Work	(? Yes 2 □ No		mjary occurre	J	
DIVISION	al or Atte safter des l Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, str	eet, factory, office	28	If. Location (Stre City or Town,	et and Number State)	or Rural	Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exam	rsician: To the best of my iner: On the basis of examiner stated.	knowledge, death nination and/or in	n occurred at the time vestigation, in my op	ne, date and place, an pinion, death occurred	id due to the cau I at the time, dat	use(s) and mand e and place, and	ner as sta id due to i	ted. the cause(s)
	To the comp	Σ	29b. Signature and title of certifier	Land		29c. License			d. Date signed		· · · · · · · · · · · · · · · · · · ·
			Joshen B.	Breento	ne MI		ME		JANUARY	25,	2004
		}	30. Name and address of person while	ompleted cause of death	(Item 🏖a) (Type,		On- 01 1	. p. 7/1			2 01001
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature		enn Street	, Baiti	more, M	aryl	ana 21201
*	Registr	ar	FFR 0 4 2004	Brace a	13 10	order!					

				State of M	laryland / Depa <i>Ce</i>		of Health a of Death	ind Mental Hy	/giene Reg. No. 2		02967		
	Physic	ian	1. Decedent's Name (First, Middle, Lest) Margaret Gertrude Kyle						eath Day	Yeer	3. Time of Death		
	/Medi		Margaret Ge	Februa			2:55a						
	Exami	ner	4e. Fecility Name (If not institution, gi Westminster Nu						r Location of Death 4c. County of Death				
Н	Francis				.er ge (In yrs. lest birthday)	If Under 1 Y		inster 24 Hrs. 8. Date of Bi	Carro		e /State or Foreign		
	Funeral Director			1 TM 2 TVC	2 Yrs.	Months De		Min. (Month, D July 3	ay, Yeer)	Country)	e (State or Foreign		
	P _		Usual Residence of Decedent			1		oury o	1911	100			
	anylar ahow	_	10a. State 10b. County 10c. City, Town or Location 10d. In Md Carroll Marriottsville 11										
	with the Maryland a or 28a-f ahow be notified at	ecto			Marri						1 ☐ Yes 2√ No		
	with t	늅	10e. Street and Number	-		10f. Zip Cod	de		10g. Citizen of	What Country	}		
20	eath w	eral	2423 Forest Hill Road 21104 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po						USA (Specify Yes or No-				
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is merkad other then "natural", or Items 23a or 28a-f ahow other traumatic evant, the Medical Examiner man be notified.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 Yes 2 If Yes, Give X Year or Detes:	No	If Yes, specify (Puerto Rican, etc.)		Black, White, etc. Specify: white			
21215-0020	n 72 hours "natural", edical Exa	8	15. Decedent's Education 16a. Decedent's Usuel Occupetion						16b. Kind of Business/Industry				
215	hin 7	Completed by	(Specify only highest grade completed) (Give kind of work done during most of well life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)						communications				
	od wil	Ş	12			ephone o	operator		Communi	cation	S		
Maryland	tal Hy d oth	Be	17. Father's Name (First, Middle, Les				18. Mother	's Name (First, Middle	, Maiden Surnar	ne)			
Z	Men Men Merka Merka Merka	ျ	Timothy J. O'Nei					na_Lynch					
Ma	d 2 should be filed within h and Mental Hygiene. F is merked other then "traumatic event, the Mes		19a. Informant's Name/Relationship Kathleen Price (d					or Rural Route Numb	-		•		
	1 an Heall em 2		20a. Method of Disposition	laughter)	20b. Place of Dispo	isition (<i>i</i> ve <i>m</i> e o	Ī	., Marriot	tsville 20c. Location	, Md 2	L104 State		
io Io	eges ant of t: if it	1 3	1 XBurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		cemetery, crer	netory or other	place)	2-5-04			Ciate		
Baltimore,	permit. Peges 1 and 2 Department of Health a Important: if item 27 is any Injury or other tra once.	l P	21. Signature of Funeral Service Lice		Cedar Hil		Idroce of Engility	11	Suitla				
B	perm Depa Impo	E 3	Daige Harght	Herber	r P.	O. Box	195 Syk	Haight Fun esville, M	ld 21784	me & Ch	napel		
Į			23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death										
3	Physician /Medical Examiner		Immediete Cause (Final										
			disease or condition resulting in death) Due to (or as e consequence of):										
	ificate be executed g physician end as the bunel-transit	i Examiner		al	Due to (or as e consec	Letice of):	Car			9	JU.		
			Sequentially list conditions, Due to (or es e consequence of):									- h	
68760,	se exectan e		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events			į							
87	physic the t	edicai	thet initiated events resulting in deeth) Last	0.	Due to (or as a conseq	uence of):				i			
	± 0 €		L	d									
Вох	eath cert attending I for use	Physician/W											
P.O.	that the de led by the a deteched f	ys	Part II. Other eignificant conditions of		- 10		cause of death?						
	es that igned b	by Pt						10	Yes 2 No	3 Probabi	ly 4□Unknown		
r Sp	quires n sig uld bi	장							an autopsy	24b. Were a	autopsy findings		
A Control of the cont								репо	performed? available prior to completion of ca of deeth?				
æ	The law ete has page 2	E						10	Yes 2 No		s 212 No		
<u>ita</u>		Be	25. Was case referred to medical	Car Barrer			26. Place of	of Death (Check only of	174				
>	Q 50 Z	To E	examiner? 1 Yes 2 140	Hospital: 1 Inpatie	ent 2 ER/Outpatien	t 3 DOA	Other: 4 Hurs	ng Home 5 ☐ Residence 6 ☐ Other (Specify)					
n of	= = a		27. Manner of Death 1 Hatural 5 Pending	28a. Date of Inju (Month, De		how injury occur							
sio	Attending of death. ector: After by the fune	cati	2 ☐ Accident investigetio	0	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Division	tal or At is efter d al Direct ed in by	Certification:	4 Homicide determined										
	To the Hospital or Attending F within 24 hours effer death. To the Funeral Director: Atter completely filled in by the funer	edical	29a. Certifier (Check only one) 1	nysicien: To the best niner: On the basis of end manner st	of my knowledge, death f examination and/or inv ated.	occurrad et the restigation, in m	e time, date end by opinion, death	place, end due to the occurred at the time,	cause(s) and ma date and place,	inner as steted and due to the	i. cause(s)		
	To the within 2 To the comple	M	29b. Signature and title of certifier	1111		29c. Lice	ense number		29d. Date signed (Month, Dey, Y				
			I Am m	Willen	-	1	254	43	210	1/200	14		
	3		30. Neme and address of person who	completed cause of d	eeth (Item 23a) (Type,	Print)	Road	43 , West	min et	or M	1021147		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	10.0	- VU - W	, vines	10101	1	/		
	Registr	ar	FFD 0 4 2004	Menc	D A	Oce Cal							

	•	For State Registrar	State of Ma	aryland	/ Depa	artment of tificate of	Health and <i>Death</i>	d Mental Hy	ygiene 2	004	0296	
		Decedent's Name (First, Middle, Last)						2. Date of D	eath		3. Time of Death	
Physicia /Medic		Henry M. Koslows	ski					Janua:	ry 30	2004	4:00 P M	
Examin		4a. Fecility Name (If not institution, give	e street and number)			4b. City, Town,	or Location of De	ath	4c. County of Death			
	5	318 Fourth Avenue					Lansdown				Baltimore	
Funeral		5. Social Security Number 6. S	ex 7. Ago M 2 ☐ F	e (In yrs. las		If Under 1 Year Months Days		in. (Month, D	ay, Year)	Cou		
Director		220-05-7360	X M 20 F	82	Yrs.			Feb.	3, 1921	Mar	yland	
land bw		Usuel Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits	
death with the Maryland ms 23e or 28e-f show Imat be notified ■	to	MD Baltimore Lansdowne							1 ☐ Yes 2 🕅 No			
r 28s	Director	10e. Street and Number			-	10f. Zip Code			10g. Citizen	of What Cou	intry?	
h witi 33a o		318 Fourth Avenue					21227		Unit	ed Sta	ates	
deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of	Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)	lo- 14. F	Race - Amen		
ING Z IZ IS-UUSO be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural; or litems 23s or 28s-? show avent, Ira Madical Examinat must be notified at	by	1 ☐ Never Married 21X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 1 If Yes, Give Year or Dates:	0 2-9-4 1-6-4	3	1 □ Yes 2X No		,			nite	
72 ho	Completed	15. Decedent's E			(Give	dent's Usual Occu	e during most of v	workina	16b. Kind of	Business/Ir	ndustry	
ithin ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use retir	ed)	•				
aryland ZIZ should be filed within nd Mental Hygiene. I marked other than umatic avent, Italia	S	6			A	ssembly	- 7	Name (First, Middle	Gener		cors	
IZING bild be filt fental Hy rked oth	Be	17. Father's Name (First, Middle, Last,							e, walden sun	iairie)		
aryla should ind Men marke umaric	ဥ	Herman Koslowski		-	401 14 15			Seiglein	han City on Toy	- Ctata 7	- Codel	
		19a. Informant's Name/Relationship (1		•		Rural Route Num			p C000)	
C, T 1 and 1 and Heattl 1 and		Louise B. Koslows 20a Method of Disposition	ki Wife	_		OURTH AV	zenue, L	ansdowne .	, MD ZI.		own, State	
IOF iges in the		1X Burial 2 ☐ Cremation 3 ☐		cen	netery, crei	natory or other pl		0.000/		,		
timer rtant		4 Donation 5 Other (Special	- A	Loud			tery 2-	2-2004 brose Fui	Balti			
Baltimore, Misperial Pages 1 and 2 Department of Health a Important: If them 27 Is any injury or other transpace.		21. Signature of Funeral Service Isice	See Oll) All (ng Rd., A				
		23a. Part1. Enter the disease, or com	plications that caused	the death.							Approximate Interval Between	
Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each is	9 292	skin	+ Hea	W- 4	ail			Onset and Death	
Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a conseque	nce of):	C // C		ailure			123.	
Examiner				Cand	in	wersh	Ky.				yrs.	
	Jer	cause. Enter Underlying Cause (Disease or injury that initiated events c.										
uted	틸											
HECONDS, P.O. BOX 68/6U, The law requires that the death certificate be executed the has been signed by the attending physician and the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as	a conseque	nce of);							
6 / 6U ate be e hysiciar the buri	dlcal	•	d	-								
ng pl	Wed	IF FEMALE:				 						
Box Bath cer attendir for use	an/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Dive birth 2 Fetal death 3 Ectopic pregnancy							(23d. Date of delivery Month Day Year		
at the dea by the at	Sici	In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown										
d by etach	Physician/Me		contribution to death h	ut not result	ing in the u	ndarking cause o	wen in Part I	23e Did	Ltobacco use c	ontribute to	the cause of death?	
dS, F	b	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰ Onknown			
COTA w requir been si should	ted	Nove facule						-				
law law	nple		COP	0				_ 24a. Wa	s an 24 opsy formed2	b. Were autoprior to condeath?	opsy findings available empletion of cause of	
	Completed							1 ☐ Yes	2E No	1 Yes	2 🗆 No	
VITAL MECOTGS, sicien: The law requires to certificate has been signe lirector, page 2 should be o	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of I	Death (Check only	one)			
Physi Physi this o	은	1 Yes 2 No	1 Inpatie		P/Outpatie	IL 3 DOA	4 🗀 Nursin	g Home 5 The		Other (Speci	ify)	
Ing F	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	8b. Time o Injury	W	ork? ☐Yes 2☐No	280. Describe	how injury occ	curred		
DIVISION OF N or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	2 Accident investigation 3 Suicide 6 Could not be	OB Class of In	iun. At hom	o tarm et	reet, factory, office		28f Location	/Street and Nu	mher or Rur	a I Route Number	
for Al	rti	4 Homicide determined	building, et	c. (Specify)	10, Idilli, St	eet, factory, office	в		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
pltat purs a prai (202 Config. 1 Cartifying Pi	nveician: To the heet	of my knowl	edge deat	h occurred at the	time date and ni	ace, and due to the	e cause(s) and	manner as	ctated	
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 39a. Certifier (Check only one) 49a. Certifier (Check only one)									to the cause(s)	
To the within 2 To the complete	Mec	29b. Signature and title of certifier	0	ALL	0.	29c. Lice	nse number		29d. Date sig	ned (Month,	, Day, Year)	
F 3 F 8		Myde	Turo,	1)1100	MO	1	3694	12	Febru	ary ?	2,2004	
JT.		30. Name and address of person who	completed cause of o	leath (Item 2	(Tyne	Print)	/	12 Catorsin	70	4 " "	1220	
10		B. TURAKHIA	MD 10	009.	Fre	durck	Rd.	glangin	cke, r	2 (%	124	
Sta		31. Date filed (Month, Day, Year)	A	rar's Signatu	re	2						
Regist	_	FEB 4 - 200	4 Stone	ABA.	5	100. 10	3		-			
DHMH 17 Rev 1/2	001		,	(ORIGIN	AL						

v	M. Kel	<u>1</u>	1 - For Amend & Unpen	d State of	Manyland	Dep 283 Ce	rtificate	of H	ealth2 Death	end Many	84H¥gi	ene 2 0	04	02969	
			1. Decedent's Neme (First, Middle, Las					2. Date of Do Month			ite of Death	<u> </u>	3. Time of Death		
-	Physici /Medi		Kevin Michael Kelley										ary 2 2004 1248		
	Examir		4a. Fecility Name (If not institution, give street and number) St. Agnes Hospital					4b. City, Town, or Location of Death Baltimore					4c. County of Death N/A		
¥	Funeral		Social Security Number 6. Security Number		7. Age (In yrs. last		If Under 1 Months I	Year Days	If Under Hours		te of Birth onth, Day,	Year)	Birthplace (State or Foreign Country)		
1	Director		213-60-3102 Usual Residence of Decedent	ØM 2□F	52	Yrs.	The state of the s				. 15,	1952		nsylvania	
j	and	}	10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits					
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show ta Medical Exprinent nast be redified at	ō	MD Balti	nore			На	1et	horpe	Α.				1 ☐ Yes X☐ No	
		Director	10e. Street and Number				10f. Zip C		потр		10	g. Citizen of W	/hat Coun	try?	
			927 Wilton Drive					2	1227		Į	Jnited	Stat	es	
		Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.	Was Deceder	nt of His	spanic Ori	gin? (Specify Yo	es or No-		- Americ		
36	be filed within 72 hours after dea ntal Hygiene. Nd other then "natural", or Items event, Ita Medical Examinat in	y Fu	1 □ Never Married 2 1 □ Yes 2 1 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:				1 ☐ Yes 2 ▼ No Specify:					Specify		ite	
21215-0036	tural	Completed by						ent's Usual Occupation 16					6b. Kind of Business/Industry		
215	hin 72	plet	(Specify only highest grade completed) (Give kind of work done during most of work Elementary/Secondary (0·12) College (1·4or 5+)						t of working		35. Tuild of 50	011103211110	Joseph		
21	e filed within at Hygiene. I other then vent, It a Me	Com	12	4	40134)	Sa	les Pe	rso	n		Advertising				
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name (First,	Middle, Ma	aiden Sumam	Ð)		
Z	12 should be f n and Mental h is marked of raumatic ever	5	Frank G. Kelley	9:11						narie Da					
Mai	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (7							or or Rural Route				Code)	
e,	1 an Heat tem 2		Lavon Kelley Wife 20a. Method of Disposition		20b. Place	of Dispo	sition (Name	of		Halethon Date	-	Dc. Location -		wn. State	
<u>o</u>	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic e ance.		1 Burial 2 Cremation 3 C		New C	athe	dral			2-6-2004		Baltim	•		
Baltimore, Maryland	mit. F portar / inju	1	21. Signature of Funeral Service Licen		1 -		Cemete. Name and		- 1	yAmbrose					
Ö	Depar Depar Impor any in	1	Dalline N Clor MO138/ 1325 Eulphur Spring Road, Arbutus, MD 21227												
	4.5		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
	Physician /Medical Examiner		Immediate Cause (Final disease or condition Multiple injuries												
			resulting in death)	Due to (c	or as a consequenc	e of):									
		-	Sequentially list conditions,	e of											
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury												
Ć.	the death certificate be executed y the attending physician and iched for use as the bunat-transit	Еха	that initiated events resulting in death) Last	e of):											
8760,		dical		d								. [
9		0	IF FEMALE:	-											
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \subseteq so 2 \subseteq No 9 \subseteq Unknown 23c. If yes, outcome of pregnancy 1 \subseteq Live birth 2 \subseteq Fetal death 3 \subseteq Ectopic pregnancy 4 \subseteq Pregnant at time of death 5 \subseteq Other (specify) \subseteq \subseteq 0 \subseteq Noncomposition (specify) \subseteq 0 \sub								23d. Date of delivery Month Day Ye			<u> </u>	
0.	at the de by the a tached f	yslc									Month Day (ear				
Δ.	that the ed by detac		Part II. Other significant conditions co	ntributing to dea	ath but not resulting	in the ur	iderlying caus	se giver	n in Part I.	23	Be. Did tobacco use contribute to the cause of death?				
Vital Records,	The law requires that ite has been signed b bage 2 should be deta	d by									1 Yes 2 No 3 Probably 4 Unknown				
S	aw requir is been s 2 should	oleted								24	a. Was an	24b. W	ere auton	sy findings available	
Re	The la ate ha page 2	ompl				-					autopsy performe	d? pr	ior to comeath?	pletion of cause of	
ita		Be C	25. Was case referred to medical examiner?						26. Place	of Death (Chec	٠,	No 11	ZVes 2	2 No	
of V	Physician: this certific ral director,	To	1 ⊈Yes 2 ☐ No		patient 2 ER/C	Outpatien	3 NOA	Other	: 4 □ Nur	rsing Home 5	Residenc	e 6 □Other	(Specify)		
n c	ter ne	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury						Work?			be how injury occurred			
Division	ten feat for: the	lcat	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident 3 Suicide 6 Could not be determined 1.1 Start Natural 2.2 Pending (Month, Day Year) Injury 2 1 Natural 2 Pending (Month, Day Year) Injury 2 1 1:18 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2								pedestrian struck by truck				
	= = = =	Certification;	4 Homicide determined	tarri, Sire	Cit				Location (Street and Withkeris al Avenue. & City or Town, State) 95 Baltimore, Maryland						
	To the Hospital o within 24 hours at To the Funeral D completely filled in		29a. Certifier 1 Certifying Phy	highwa sician: To the b	est of my knowledg	ge, death	occurred at t	he time	, date and	d place, and due	to the cau	sels and man	nor ac eta	tod	
	the Ho in 24 the Fu ipletel	edical	(Cirect only 2 🔀 Medical Exami one)	and manne	sis of examination a	ind/or inv	estigation, in	my opir	nion, deatl	h occurred at th	e time, date	and place, ar	nd due to t	the cause(s)	
	With To 1	Σ	29b. Signature and title of certifier						29c. License number			29d. Date signed (Month, Day, Year)			
			Jashary 18	West.	sey M	D			OCME 		F.6	ebruary 3 2003			
			30. Name and address of person who co	empleted cause) (Type, F		Do	nn C	treet 1	Raltin	nore M	[arv1	and 21201	
14	Sta	te	31. Date filed (Month, Day, Year)	, 32. Re	gistrar's Signafure	1		LIC	TH1 ()	шест, і	للها عيمات	iole, P	YLY L	CIRC CIECT	
9	Registr		FFB 0 4 2004	Serve	D	100	and s								

_			,	1 - For State Registrar	State of Maryla			of Health and of Death	R	eg. No. 20	
		Physicia /Medic		Decedent's Name (First, Middle, La Edward Jay Kec	k				2. Date of Dea Month January	Day 28, 200	
٦		Examin Funeral			Hospice Sex 7. Age (In y	rs. last birthday)	Timon		s. 8. Date of Birth (Month, Day	, Year)	of Death Cford 9. Birthplace (State or Foreign Country)
		Director		219-56-2912 Usual Residence of Decedent 10a. State 10b. County	5	City, Town or Lo	ocation		Dec. 24	, 1952	Tennessee
	e Maryla	Sa-f shov	ctor	Maryland Harford		Bel A	ir	·			1 ☐ Yes 2, ☐ No
	with th	n or 20	Director	10e. Street and Number			10f. Zip Co		1	log. Citizen of W	-
	eath	7 23 Tales	erai	840 Flintlock D	12. Was Decedent Ever in	n U.S. 13.		015	Specify Yes or No-	USZ 14. Race	- American Indian,
:25 p.m 5-0036	within 72 hours after death with the Maryland	rai", or iteme 23a or 28a-f show Exemples must be rediffed at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates:			of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	rto Rican, etc.)	Specify:	white, etc. White
2:25 215-01	hin 72 ha	and Mental Hygiene. is marked other than "natural", or sumatic event, the Medical Exami	Completed by	15. Decedent's E (Specify only highest gi		(Give	dent's Usual O kind of work o DO NOT use r	lone during most of w		16b. Kind of Bus Harford	County
5	1 B.	Hygiene. other ther ent, the	Соп	12		Depu	ıty 1st	. Class			s Office
.8, 2004 Maryland	should be fill	Mental Hi arked oth atic even	To Be	17. Father's Name (First, Middle, Las Claude Wesley	Keck, Sr.			Glenna	Mae He	Maiden Sumame 11ard	o)
χ. <u>Τα</u>	2 sho	is mark	1 7	19a. Informant's Name/Relationship			ar re	treet and Number or F			
•		Health em 27 ther tr		Constance Keck 20a. Method of Disposition	/ Wife	b. Place of Dispo	sition (Name o	ck Drive.	Bel Air,		od 21015 City or Town, State
ak Y	8	t: If it		1 Surial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery, crei	natory or othe	r place) scopal 2-2-	-04		, Maryland
JANUAKY	permit. P	Department of Health and Mental Hygiene, important: if Item 27 is marked other than "naturany injury or other traumatic event, the Midical once.		21. Sign ture of Funeral Service Lice							aryland 21009
	ec.	9		23a. Part1. Enter the disease, or cor shock, or heart ailure. List only	plications that caused the						Approximate Interval Between
68760	Executed to be executed	ysician and hybrician and hybridian-transit the burial-transit	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	sequence of):					
O BOX	the death cer	signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	□Ectopic pregr □ Other (speci			23d. Date Mon	of delivery th Day Year
و ا	quires that	n signed b uld be deta	þ	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying caus	e given in Part I.			bute to the cause of death? 3 ☐ Probably 4 ▼Unknown
Vital Becords	The The	s certificate has been si lirector, page 2 should l	Completed						24a. Was a autops perfor	sy pi med? d	lere autopsy findings available rior to completion of cause of eath? Yes 2 \(\subseteq \text{No} \)
UWAR Vital	Physicien:	certif	Be C	25. Was case referred to medical examiner?	Hospital:	o C Ett/Outpation		04	eath (Check only or		
Č	- E	After this funeral o	tion; To	1 Yes X No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 28a. Date of Injury (Month, Day Year			injury at Work? 1 Yes 2 No	Horne 5 Residence Residenc		THE PARTY OF THE P
Division	al or Atter	after death. Director: A d in by the fu	ertifica	3 Suicide 6 Could not determine		At home, farm, str ecify)	reet, factory, of	ffice	28f. Location (S City or Town	treet and Numbe n, State)	r or Rural Route Number,
*	Ne Hospitai	within 24 hours after death To the Funarel Director: completely filled in by the	Medical Certification;	29a. Certifier (Check only one) Certifying F	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at t vestigation, in	he time, date and pla my opinion, death oc	ce, and due to the courred at the time, d	ause(s) and mar late and place, a	nner as stated. nd due to the cause(s)
	To th	within To 11 comp	ž	29b. Signature and title of certifier			29c. L	cense number	2	9d. Date signed	(Month, Day, Year)
	•	Λ			15-			143725		1/28	164
		8		30. Name and address of person who						//	,
ı		-01		DR. TARIQ MAHM 31. Date filed (Month, Day, Year)	OOD 2300 DUL. 32. Registrar's S		1 .		M, MD 210)93	
		Sta Regist		51. Date med (Month, Bay, 19a)	Agran	19 1	oaker	/			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 30°, Brenda Ann Kistner January 2004 7:00 A.M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Raspeburg Baltimore 6110 Everall Ave If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth Month Day, Year 4/13/1941 Birthplace (State or Foreign Country)
 WISCONSIN **Funeral** 1 M 201F 213 40 1575 Director Usual Residence of Decedent fited within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f show the Madical Examiner must be notified at Baltimore Raspeburg MD 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 6110 Everall Ave 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other freumatic avent, the Madic once. Elementary/Secondary (0-12) College (1-4or 5+) St. Joseph Hospital Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNO Robert Olson Evelyn Hansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Richard Kistner Husband 6110 Everall Ave Raspeburg, Maryalnd 21206 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2/2/04 Catonsville MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature d'Eun ral Service Licensée 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw onset and Death Immediate Cause (Final disease or condition resulting in death) multiforme Glioblustoma **Physician** /Medical Due to (or as a consequence of) Examiner ichetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No 2 After the funeral of 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after deau. 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral L 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Paul B Fowler, Medical DOCTOR January 30,2004 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Calvert Street Baltimore, Maryland 21218 3400 North Paul B. Fowler, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State CONTRACT. Registrar

			ricase	State of Manuary				c Legibic.	
			For State Registrar	State of Maryland	Certificate		Reg.		02972
	Physicia	an	1. Decedent's Name (First, Middle, La		Le			Day Year	3. Time of Death
	/Medic	al	LAWIEN C 4a. Facility Name (If not institution, give			wn, or Location of Death		25 2004 4c. County of Death	1748 4
1	Examin	er	Howard Cont	General Ho	- 1-1 - 2)	mb14, M	/ 1 /	Howa	rd
	Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs. It	last birthday) If Under 1		8/Date of Birth (Month, Day, Ye	9. Birthp G47 Triv	place (State or Foreign
	g		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location			1	Od. Inside City Limits
	Maryla -f shor	ţ	Moryland Howa	I	olumbia				15⊈Yes 2□No
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumatic event, the Modical Examiner must be notified at	Director	10e. Street and Number		Apt. 10f. Zip Co	ode	10g.	Citizen of What Cour	ntry?
	eath w	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. Was Deceden	1044 nt of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ	
ဖွ	after d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Cuban, Mexican, Puerto No <i>Specify:</i>	Rican, etc.)	Black, White,	etc.
21215-0036	hours ture!',	ed by	3 Widowed 4 Divorced	Year or Dates:	16a, Decedent's Usual C	Occupation		. Kind of Business/In	2CK dustry
75	ın 72 ın "na Mədic	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of work of life. DO NOT use	done during most of work	king	. 1 r	i.
7	filed with Hygiene other tha	Com	9	0	Labore		<u> </u>		terprises
Maryland	be file	Be	17. Father's Name (First, Middle, Last	" Laka		Handr	ne (First, Middle, Maid	Vaarula	1
<u> </u>	should ind Men ind marke umatic	၉	19a. Informant's Name/Relationship	(Type, Print) (Wife)	19b. Mailing Address (S	Street and Number or Rui	ral Route Number, Ci	ty or Town, State, Zip	Code) 21044
1111	and 2 salth ar a 27 is er treu		Mrs. Ermine	Lake	5895 Ha	irpers Fi	arm Rd.	Columbi	a NId.
ore	2°= 5		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 [☐Removal from State	lace of Disposition (Name emetery, crematory or othe	of propriace)	2004 I	Location - City or To	own, State
Baltimore,	Pa		 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice 		1T, 2100 22. Name and	Address of Facility		unsaov	me, ma.
Ba	permit. Departm Importe any inju	i is	Jasenk	L. Kuss	Joseph y	1. North AV	e Balto	und 21	<u> 16</u>
			, 23a. Part . Enter the disease, or conshork, or heart failure. List only	nplications that caused the death y one cause on each line.	h. Do not enter the mode of	of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. A MMA	heuce of).				
	Examiner		Sequentially list conditions	b					
-	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):				
Ť.	be execut ician and burial-trar	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequ	uence of);				
3760,	5 S 6	cai		d					
89 x	certific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregna	ancy		_	23d. Date of delive	erv
). Box	the death certifica y the attending ph iched for use as th	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of de 9 ☐ Unknown				Month	Day Year
P.O.	that the de led by the detached	, Phy	Part II. Other significant conditions	contributing to death but not resi	ulting in the underlying cau	se given in Part I.	23e. Did tobacc	co use contribute to the	he cause of death?
rds	w requires been signi should be	ed by					1 Ves	2 No 3 Prob	pably 4 Unknown
Vital Records,	2 S S	Completed					24a. Was an autopsy performed	prior to co	psy findings available impletion of cause of
al B		e Cor	25. Was case referred to medical			26 Place of Dea	1 ☐ Yes 2 ☐		20No
Z:	Physicien: r this certific ral director,	0 8	examiner?	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient 3 □ DOA	Other		e 6 □Other (Specif	ý)
n of	De ig	lon: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	: Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how it	njury occurred	
Division	5 ta :: 6	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of Injury - At ho	ome, farm, street, factory, o		28f. Location (Street City or Town, St	t and Number or Rura	al Route Number,
ĕ	rs after rel Dire		4 Homicide	building, etc. (Specin)	· · · · · · · · · · · · · · · · · · ·				
	To the Hospitel or Atter within 24 hours after de To the Funerel Directo completely filled in by th	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death occurred at tion and/or investigation, in	the time, date and place, 1 my opinion, death occur	, and due to the cause rred at the time, date	a(s) and manner as s and place, and due to	tated. the cause(s)
	within To the comple	₹ E	29b. Signature and title of certifle	1.	29c. 1	License number	29d.	Date signed (Month,	Day, Year)
			> the	and I !		04132	OJ		,2004
			-//	o completed cause of death (Item		V4. Col	umbit, 1	nd - 210	44.
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa					
	Registi	rar	FEB 0 4	I LUUIT PARTE	A. Ballana				

			T lease	State of N							lental Hy		•			
		•	For State Registrar			-	rtificat					Reg. No.	7 11 11	Ly (029	73
	Physici	an l	1. Decedent's Name (First, Middle, Las								2. Date of De Januar	_	a a Xea		3. Time of De	
5	/Medic				Brecque		1				Januar		, 2004		0620	М
	Examin	er	4a. Facility Name (If not institution, give						Location	of Death			County of D			
	Funeral		Uppper Chesapea 5. Social Security Number 6. Se		Age (In yrs. It		If Under	l Ai	If Under		8. Date of Bir (Month, Da		Tarfor		e (State or Fo	oreign
	Director		014-20-7742		77	Yrs.	Months	Days	Hours	Min.	Nov. 1	7, 19	926 M	Country) Iassa	chuset	tt_
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	ocation							10d	Inside City L	imits
	Aanyla f sho	5		I	100.000										1 🗆 Yes 2	
	28a-	Director	Maryland Harford 10e. Street and Number			Joppa	10f. Zip					10g. Citiz	zen of What	Country?	?	
	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show fre Modical Exerciter man be motified at	<u>e</u>	671 Trimble Road	Ĺ				2108	5				US	Α		
	ems %	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S	3. 13.	Was Deced	dent of Hi	ispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.))- 1	14. Race - A			
36	or its	by Fu	1 Never Married XX Married 3 Widowed 4 Divorced	1 ☐ Yes 2¥ If Yes, Give	□ No		1 ☐ Yes				,		Specify:			
8	fural'	ed b	15. Decedent's Ed	Year or Dates	s:	16a. Dece	dent's Usua	al Occupa	ation			16b Kir	nd of Busine	Whit ss/Indust		
15	nin 72 In "na	piet	(Specify only highest grad	de completed) College (1-4d	or 54)	(Give life.	kind of wo DO NOT us	rk done d se retired	during mos)	t of work	ing	, , , , , , , , , , , , , , , , , , , ,			,	
212	d with giene.	Completed	12	55110g0 (1 40	51 51)	Homem	aker					Own	n Home			
nd	be filed tal Hygid d other evant, I	Be	17. Father's Name (First, Middle, Last)								e (First, Middle		Sumame)			
Maryland 21215-0036	should be find Mental himarkad of	ဥ	2	Simard		10h Maili		(Cteant e	Ida	,		Brie	Tour Ctate	7in Co	de l	
<u>B</u>	d 2 sho th and 7 Is mu traum		19a. Informant's Name/Relationship (7) Elaine Quinn / D			1				_	a <i>l Route Numb</i> Bel Air				σ e)	
	to and Health tem 27 tem 27 other to		20a. Method of Disposition		20b. PI	ace of Dispo metery, crei					Date	•	cation - City		State	
e E	Pages ent of nt: If If		1 Burial 2 Cremation 3 ☐ 4 Donation 5 Other (Specify		ILE	Air .			1	5. 2	2-2-04	Bel	Air.	Marv	land	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show importants if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it's Macilian Expandible 1 and DDCs.		21. Signature of Funeral Service Licens		, 201						ome, P.					
ω_	89 5 8		Stessen Cell	Jugs			1317	Coke	sbury	Roa	ad, Abii	ngdor	n, Mar	ylan	d 2100)9
4			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caus ne cause on each	sed the death h line.	. Do not ent	ter the mod	e of dying	g, such as	cardiac	or respiratory a	rrest,		Int	proximate erval Betweenset and Dea	
7	Pnysician	4 7	Immediate Cause (Final disease or condition resulting in death)	a. auti	eres	lew	la	Cu	ste	war	elen	de	ere	0.		
	/Medical Examiner		Tooling in doain,	Due to (or	as a consequ	ence of):								1		
		ا ق	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ence of):										
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.												
ó	te be executed ysician and te burial-transit	E	resulting in death) Last		as a consequ	ence of):										
8760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	lical		d										-		
x 68	Physician: The law requires that the death certifica this certificate has been signed by the attending phraid director, page 2 should be detached for use as it	/Med	IF FEMALE:	23c. If yes, outcor	me of pregnar	nev							04.0-44	4-0		
Вох	attend for us	Physician/M	in the past 12 months?	1 ☐ Live birth	2 ☐ Fetal t at time of de	death 3	Ectopic pr					2	3d. Date of o Month	Day	y Yea	r
P.O.	the d by the ached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknowr			J - 111-01 (-)							100		
ď.	res that igned b be deta	Y P	Part II. Other significent conditions co	ntributing to death	h but not resu	Iting in the u	nderlying c	ause give	en in Part I		23e. Did t	obacco us	se contribute	to the c	ause of deat	h?
Records,	w require been sig should b	ed t	recent hyp	use	·				-		1 🗆 '	Yes 2□	□No 3 🗆	Probably	√ ↓ □Unki	nown
ဝင္ပ	law re as be	plet	congestive!	Lout,	Luly	0					24a. Was	osy	prior t	o comple	findings ava	ilable e of
H	The cate h	Completed by									perfo	rmed?	death 1 🔲 Y) No.	
of Vital	sician: The law certificate has b lirector, page 2 s	Be	25. Was case referred to medical exeminer?	Hospital:				Othe	200		h (Check only o					
o	Phys rthis ral dir	2 2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Impa 28a. Date of I		P/Outpatier 28b. Time o		//	4 🗀 140		me 5 Resident			oecify)		
lo	Attending For death. ector: After by the funer.	igi	1 Natural 5 Pending 2 Accident investigation	(Month, I	Day Year)	Injury	м	8c. Injury Work	<br Yes 2 □			,				
Division	Atter	ifica	3 Suicide 6 Could not be determined	28e. Place of	Injury - At hor	me, farm, sti	eet, factory	, office			28f. Location (. City or Tox	Street and	Number or	Rural Ro	oute Number	,
Ö	ospital or Attendi hours after death. unerel Director; A ly filled in by the fu	Cert	4 D Homodo	building,	etc. (Specify,						Ony 01 701	wii, State)				
V	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Certification:	29a. Certifier (Check only 2 Medicel Exam	iner: On the basis	s of examinati	vledge, deat ion and/or in	h occurred vestigation.	at the tim	ne, date an pinion, dea	id place, ith occuri	and due to the red at the time.	cause(s)	and manner place, and d	as stated	d. e cause(s)	
6	To the Ho within 24 I To the Fu completely	Med	one) 29b. Signature and title of certifier	and manner	stated.				number				signed (Mo			
	5 1 ki 3		255. Signature and time of certifier				230									4
•	di		30. Name and address of person who d	completed cause	of death /Item	23a) (Type	Print)	3	227)		וענו ל	0.067	29,	200	/
	`		David 5 De	3 /	1	-1 2.	1 - 26	A. 1	B.	e(0.	r sup					
	Sta	ate	31. Date filed (Month, Day, Year)	32 egi	istrar's Signat	ure			-			-				
	Registi	rar	FFB 0 4 20	14 1500	yas l	A 282										

DHMH 17 Rev 1/2001

1/29/04 0620

Labrecque, Gertrude #079733

State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 L For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 1, 2004 **Physician** LEVIN 5:52 MARSHALL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CENTER TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year, NOV. 22, 1920 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 **X** M 2□ F 215-14-4580 83 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show event, the Medical Examiner must be notified at 1 TX Yes 2 □ No BALTIMORE Directo N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö U.S.A. 21209 6106 IVYDENE TERRACE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No WHITE ģ 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AT LAW JUDGE other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 0. LEVIN ROSE DELAVIEZ HARRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 BOXRIDGE COURT - OWINGS MILLS, MD 21117 SUSAN LIEMAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD ANSHE EMUNAH (AITZ CHAIM) 2/3/2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tracevebral Hemorrhage Immediate Cause (Final disease or condition resulting in death) Acute **Physician** M /Medical Due to (or as a consequence of) Examiner Esquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) (105016 Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred il or Attending Patter death. 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours at To the Funeral D completely filled it 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1)25205 who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Balto Md 21204 6BMC 82. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrer	State of	Maryland	d / Depa <i>Cei</i>	artmen rtificat	t of H	lealth and M	lental Hy	giene Reg. No. 2	004	02975
			1. Decedent's Name (First, Middle, I	ast)						2. Date of De			3. Time of Death
	Physici /Medio Examir	cal	REVEREND J			LERCH,		Town, or	r Location of Death	Month Januar	y 29, 2 4c. Count	Year 2004 by of Deeth	3:30 P ^M
3-30 f.m.	Funeral Director		HOSPICE OF BALTI 5. Social Security Number 6 214-20-9501		CHRIST 7. Age (In yrs. la 77		If Under Months	1 Year	VSON If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da May 1,	Balti ^h 7. Year) 1926	9. Birtho	County olace (State or Foreign try) yland
3	P .		Usual Residence of Decedent		10-01-	. Town or Lo							Od. Inside City Limits
	arylar ehow	_	10a. State 10b. County	•	TOC. City							'	1 Great 2 □ No
7	n the Marylar r 28a-f ehow	Director	Maryland N/	A		Balti						l.	Λ
324	라 다 6 22	Olre	10e. Street and Number				101. Zip	Code			10g. Citizen of	What Cour	itry?
Z	death with the Maryland ma 23a or 28a-f ehow rmant be notified at	-B	5704 Roland Av						L210			ISA	
3		Funeral	11. Marital Status	Armed For		S. 13. \	Was Dece If Yes, spe	dent of H cify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Ble	ce - Americ eck, White,	
200 %		by Fu	1 Never Married 2 Married	If Yes, Give	² ∏ ^{No}		1 🗌 Yes	2 ₽ No	Specity:		Speci	∜∵ Whi	itα
January 21215-0036	72 hours after "natural", or ite	D D	3 Widowed 4 Divorced	Year or Da	ites:						401-16-4-45		
3 4	2 E S	Completed	15. Decedent's (Specify only highest of			16a. Deced	dent's Usua kind of wo	nk done d	ation during most of worki f)	n <i>g</i>	16b. Kind of E	dusiness/in	dustry
3 5	within 72 ene. than nat	d m	Elementary/Secondary (0-12)	College (1- 5+			holic				Christ	ian M	linistry
17 5	should be filed within of Mental Hygiene. marked other than matic avent, the M	ပိ	17. Father's Name (First, Middle, La			Oat	HOTTC	- 111	18. Mother's Name	(First, Middle.			Inistry
Ž	ould be t Mental t arked of atic ave	Be										,	
چ څ	J Me J Me nark natio	T ₀	Charles S. Ler			10h Mailie	na Addross	/Stroot	Margar and Number or Rura	et E.		State Zin	Codel
ech, Jacoh Baltimora Maryland	3 " 5 - 3		Rev. Michael D.		т		_				·		
5	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra		20a. Method of Disposition	rench, so		ace of Dispo			Avenue, I	Saltimo: Date	20c. Location		
_ 5	or o		1 Surial 2 ☐ Cremation 3		State C6	metery, cren	natory or o	ther plac	(0)			20 6	
OCh.	tmer tant		`4 ☐Donation 5 ☐ Other (Spe		Jes	suit C			2/3/2		Woodst	ock,	Maryland
क द	permit Departiment Impo		21. Signature of Funeral Service UK		^	M	itche	11-W	ss of Facility Viedefeld	Funera	Home.	Inc.	
ے د	00390		Martin_D. L	iwson		16	500 Y	ork	Road, Bal	timore	, Maryl	and 2	1212
•	Physician /Medical		Martin D. Li 23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_aC	or as a consequ	Can			g, such as cardiac c	or respiratory at	rest,		Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	or ns a consexiu	anos of):							
08760	icate be executed physicien and transit	cal	that initiated events resulting in death) Last	Due to (d	or as a consequ	ence of):							
Division of Vital Records P O Rox 68	Hospitat or Attending Physician: The law requires thet the death certificat 44 hours after death. Funeral Director: After this certificate has been signed by the attending phyliely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Fetal ant at time of de	death 3	Ectopic pi Other (sp					ate of delive onth	ery Day Year
ر م	wrequires thet it been signed by should be detac	d by Ph	Part II. Other significant conditions	contributing to dea	ath but not resu	lting in the ur	nderlying c	ause give	en in Part f.		obacco use con ∕es 2□No		ne cause of death?
Reco	ysiclan: The lawrents certificete has bee	Completed								24a. Was autop perfo 1 Yes	rmęd?	Were autoprior to cordeath?	psy findings available mpletion of cause of 2 No
<u>.</u>	iclan: Th certificete rector, pag	Be (25. Was case referred to medical examiner?						26. Place of Death	(Check only o	ne)		
>	Physic this ce al direc	10	1 ☐ Yes 2 № No	Hospital: 1 🗆 In	npatient 2 2	ER/Outpatien	t 3□ D0	Oth	er: 4 🗌 Nursing Ho	me 5 Resid	dence 6 Ot	her (Specify	, hospice
2	ittending Ph death. ctor: After th the funeral		27. Manner of Death 1 Natural 5 Pending investigat	ion	f Injury h, <i>Day Year)</i>	28b. Time of Injury	M 2	8c. Injun Work 1 🗆	/ at k? Yes 2 □ No	28d. Describe h	now injury occu	rred	
o ivid	tal or Attences after death	Certification:	3 Suicide 6 Could not determine	288. Place	of Injury - At ho ig, etc. (Specify	me, farm, str	eet, factory	, office		28f. Location (5 City or Tox		ber or Rura	I Route Number,
ix	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Ex	Physician: To the laminer: On the ba and mann	sis of examinati	viedge, death ion and/or inv	vestigation	, in my o	ne, date and place, a pinion, death occurr	ed at the time,	date and place,	and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				290	. License	number		29d. Date signe	ed (Month, I	Day, Year)
	-		Atra	X.				DS	8303		JANON	امر عر	, 2009
_	10		30. Name and address of person when A Charles	eks mo	660	W 10	Print)	ror	8303 Les Ex (sell ten	ine m	0212	204
	Sta Regist		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signat	ure	1						

			For	State of Maryland			nt of Health and New Yearth			2004	02976
			Registrar 1. Decedent's Name (First, Middle, Last)		Cert	iiiCai	e or Death	2. Date of Dea	eg. No.		3. Time of Death
	Physicia	an	11 a - 1 10 0	Mª mil	1 a N			Jan Va	Day	29-2004	4.43PM
X	/Medic Examin		4a. Fecility Name (If not institution, give str		1911	4b. City	Town, or Location of Death		17	ounty of Death	1/0
н	LXamin	C1		2 Commo	NS	Ca	tons Vil	le	130	alti m	ore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under	r 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day	Year)	9. Birthpla Count	ace (State or Foreign
H	Director		240-42-5733	76	Yrs.			2-13		′/	"NC
	land	}	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10	d. Inside City Limits
	Mary -f ehc	ğ	md	13	a1+	im	ore				1 Yes 2 No
	h the	Director	10e. Street and Number			10f. Zi	Code	1	0g. Citize	on of What Count	en.
	death with the Maryland me 23a or 28e-f ehow r must be rollified at	aiD	2700 Chelses	terr			21216			U. S.F	<i>t</i> ,
	r dea	Funerai	Tr. Warter States	. Was Decedent Ever in U.S Armed Forces?	i. 13. W	/as Dece Yes, spe	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14	I. Race - America Black, White, e	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Dovorced	1 ☐ Yes 2 ☐ No tf Yes, Give Year or Dates:	1	□Yes	2 No Specify:		s	ipecity: 15	966
ခို	ould be filed within 72 hours after Mental Hygiene. arked other than "naturat", or Ite. artic event, the Medical Examinat		15. Decedent's Educa	tion	16a. Deced	ent's Usi	al Occupation		16b. Kind	of Business/Ind	ustry
215	hin 7. P. Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT	ork done during most of work use retired)	king	1		10
2	or the	Con	12+11		HO	m e	Care Pri	Videc	P	riva	TE
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	D + 01 01	. 1		18. Mother's Nam	ne (First, Middle,	Maiden S	umame)	
Maryland 21215-003	should be filed within 72 hours after death with the Marylan and Mertal Hygiene. Ind Mertal Hygiene. Inarked other than "naturat", or itema 23a or 28e-f ehow marked other than "naturat" or itematic event, the Medical Exambrat merminal be notified at	٥	19a. Informant's Name/Relationship (Type	Cutchei		a Addras	s (Street and Number or Ru	N C	City or	n 1 + h	Code
<u>a</u>	d 2 sho th and 7 is m traum			air sister		-	Callawa	-	a 1+	and	11215
ē,	Health tem 27 thar tr		20a. Method of Disposition	20b. Pla	35 ace of Dispos	SIRROLL (149	me of		20c. Loca	ation - City or Tov	wn, State
ltimore,	Pages nent of int: if it		1	moval from State 1	metery, crem A W M	,		7-04	Red	Sprin	9 NC
alt:	그는 판구		21. Signature of Funeral Service Licensee		22.	Name a	nd A dress of Facility				
Bal	Departing Department of the poores.		Wesley Cha	MI		200	17 FOCKEDYO	AVE	100	110 m	31
þ			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.	Do not ente	er the mo	de of dying, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition	Metasta	UTIC		lultiple	Mye	101	ma	140ur
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):		/	,			·
	2) L	Sequentially list conditions, b.	Due to (or as a consequ	ence of):						
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
,	execu n and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):				-		
8760,	cate be executed physician and s the burial-transit	dical	d.								
9	E 00 6	Medi	IF FEMALE:								
Вох	eath certific attending p	an/h	23b. Was decedent pregnant in the past 12 months?	 c. tf yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetat 	death 3		pregnancy		23	d. Date of deliver Month	ry Day Year
O.	the at	sici	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5□	Other (s	pecify)				,
P.O.	w requires that the death certific been signed by the attending p should be detached for use as	by Physician/Me	Part II. Other significant conditions cont	ributing to death but not resu	lting in the un	nderlying	cause given in Part I.	23e. Did to	bacco use	e contribute to th	e cause of death?
ds,	signe signed d be	d by	Hyl	Verteusio.	n		•	1 □ Y	es 2 🗆	No 3 ☐ Proba	ably 4. ©Unknown
COL	been been shoul	lete						24a. Was a	ın	24b. Were autor	osy findings available
Re	hyaicien: The law his certificate has b I director, page 2 sl	Completed						autop: perfor	sy med? 2₽ No	prior to con death? 1 ☐ Yes	npletion of cause of
tal		O	25. Was case referred to medical				26. Place of Dea	th (Check only or			220110
Ž	Phyaicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ② No	spital: 1 Inpatient 2 E	ER/Outpatien	t 3 🗆 🗅	OA Other: 4 X Nursing H	ome 5 Resid	ence 6	Other (Specify)
0	ng Ph fter th neral	ü.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?	28d. Describe h	ow injury	occurred	
Sio	tendin eath. or: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2 No	204 1 (2		N	Contract to the second
Division of Vital Records,	or At ifter d Direct in by	ertification;	4 Homicide determined	28e. Ptace of tnjury - At ho building, etc. (Specify	me, tarm, stre	et, facto	ry, office	City or Tow		Number or Rurai	Houle Number,
٢	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	O	29a. Certifier 1 Certifying Physi	cian: To the best of my know	vledge, death	occurre	d at the time, date and place	, and due to the o	ause(s) a	ind manner as sta	ated.
	• Hos 24 h • Fur letely	edical		er: On the basis of examinat and manner stated.							
	within To th compl	Me	29b. Signature in title of certifier	6.06		2	c. License number		29d. Date	signed (Month, L	Day, Year)
	^		I lold Attill	ding 11750	10n		D53642		Jan	uary:	31 2004
	1)-		30. Name and address of person who cor	npleted cause of death (trem	23а) (Туре,	Print)	n Blud	203 E	20-	+mlvo	71735
			31. Date filed (Month, Day, Year)	32 Banistrar's Signat	UN /<	CVR	n Diva.	1000	cex (, more	010)
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signat	To So	OBLA	21				

Physic	ian-	1 - State RegistraMEND ITEM 16b 1. Decedent's Name (First, Middle, Last,	PER FH G828 2/04/04 JAP	partment of Health and I pertificate of Death	Reg. N 2. Date of Death Month Di	
/Medi Exami	cal	Eugene 4a. Facility Name (If not institution, give	Duffie street and number)	McFadden 4b. City, Town, or Location of Death	February	
Funeral Director		2506 McHenry St 5. Social Security Number 251-24-1137 Usual Residence of Decedent		Baltimore If Under 1 Year	8. Date of Birth (Month, Day, Year 02. 04	9. Birthpleca (State or Foreig Country) 25 SC
the Maryland 28e-f show	ector	10a. State 10b. County MD NA 10e. Street and Number	10c. City, Town or I	ce		10d. Inside City Limit 1∑ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f ahow any injury or other treumatic event, the Medical Examinet must be notified at Once.	by Funeral Director	2506 McHenry S		10f. Zip Code 21223 . Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerting Yes 1□ Yes ₩ Specify:		U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black
filed within 72 ho Hygiene. ther than "netur nt, the Madical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 5th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+) (Giv life.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Grain Operator	king	NTRAL SOYA
should be f ad Mental h marked of matic eve	To Be	Jerome McFadden 19a. Informant's Name/Relationship (Ty	pe Print) 19h Mai		• McFadde	n
ages 1 and 2 and 2 and 2 and 5		Regena Snowden— 20a. Method of Disposition 1XXivial 2 Cremation 3 P	Daughter 5 Bi 20b. Place of Disp cemetery, cre 20c. Place of Disp	osition (Name of amatory or other place)	ings Mill Date 20c. L	S. Md 21117 ocation - City or Town, State
permit. Pa Departmen important any injury		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Linense	n (ee	vn Cemetery 2/7 22.Name and Address of Facility Narch F/H West 1300 Wabash Ave		ltimore Co, Md re Md 21215
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the eath. Do not en e cause on each line.		or respiratory arrest,	Approximate Interval Between Onset and Death
death certificate be executed e attending physician and id for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
The law requires that the der ste has been signed by the a page 2 should be detached for	by	Part II. Other significant conditions con	tributing to death but not resulting in the (underlying cause given in Part I.		use contribute to the cause of death?
	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
nding Physicien: The I.th. th. : After this certificate has funeral director, page	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 sesidence 28d. Describe how inju	6 □Other (<i>Specify</i>) ry occurred
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attention properties in by the funeral properties or mpletely filled in by the funeral properties.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
To the Hospital or within 24 hours after To the Funeral Director or models of the filled in the fill	Medical	one)	icien: To the best of my knowledge, deat ler: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occur	red at the time, date and	d place, and due to the cause(s)
CT W C S	2	29b. Signature and title of cert fler	MP	29c. License number D 16354	29d. Da	te signed (Month, Day, Year)
7		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type, $\mathcal{T} \cap \mathcal{S}$	Print)	W	NO 21229

Example of the state of the sta		give street and number)	(In yrs. last birthda 88 Yrs. 10c. City, Town or Balting ver in U.S. 1:	If Under 1 Year Months Days Location 10 Ce 10f. Zip Code 212 3. Was Decedent of H	ride or Location of Death or City if Under 24 Hrsi Hours Min.	acifu Yas or No	Day 7 4c. Count th, Year) 22 16	What Count	NC Od. Inside City Limi XXYes 2□N try?
To mean and mental hygiene. If them 27 is marked other than "natural", or itema 23s or 28s-f show and the marked other traumatic event, its Medical Examinar mark be notified at the medical examination of the me	4a. Facility Name (If not institution, 5. Social Security Number 240-32-1790 Usual Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number 5519 Rubin Ave 11. Marital Status 1 Never Married 2 Marrie 12 Never Married 15. Decedent (Specify only highest Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, L. Archie 19a. Informant's Name/Relationsh	12. Was Decedent E Armed Forces? 1 Yes 2 Ne I Yes, Give Year or Dates: S Education grade completed) College (1-4or 5+ na	(In yrs. last birthda 88 Yrs. 10c. City, Town or Baltin	4b. City, Town, c Set 1 1 1 Funder 1 Year Months Days Location Ore 10f. Zip Code 212 3. Was Decedent of Fill Yes, specify Cubic 1 Yes 2 No	or Location of Death Fig. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	8. Date of Bir (Month, Da	Day 7 4c. Count th, Year) 22 16	y of Death 9. Birthpli Count What Count S. A.	ace (State or Foreity) NC Od. Inside City Limit XXYes 2 \(\triangle \) Try?
The act of marked other than "natural", or itema 23a or 28a-f ehow the control of	4a. Facility Name (If not institution, 5. Social Security Number 240-32-1790 Usual Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number 5519 Rubin Ave 11. Marital Status 1 Never Married 2 Marrie 12 Never Married 15. Decedent (Specify only highest Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, L. Archie 19a. Informant's Name/Relationsh	12. Was Decedent E Armed Forces? 1 Yes 2 Ne I Yes, Give Year or Dates: S Education grade completed) College (1-4or 5+ na	(In yrs. last birthda 88 Yrs. 10c. City, Town or Baltin	4b. City, Town, c Set 1 1 1 Funder 1 Year Months Days Location Ore 10f. Zip Code 212 3. Was Decedent of Fill Yes, specify Cubic 1 Yes 2 No	or Location of Death Fig. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	8. Date of Bir (Month, Da O 1	4c. Count th y, Year) 2 16	9. Birthpli Count What Count S. A.	ace (State or Foreitry) NC Od. Inside City Limi XXYes 2□N
The marked other than "natural", or itema 23a or 28a-f ehow as under traumatic event, its Medical Examiner resist be notified at to the Total Francisco of the marked of t	5. Social Security Number 240-32-1790 Usual Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number 5519 Rubin Ave 11. Marital Status 1 Never Married 2 Marrie (Specify only highest Elementary/Secondary (0·12) 11th grade 17. Father's Name (First, Middle, L. Archie 19a. Informant's Name/Relationsh	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates: s Education grade completed) College (1-4or 5+ na	(In yrs. last birthda 88 Yrs. 10c. City, Town or Baltin	Location 107 C 10f. Zip Code 212 3. Was Decedent of Highes, specify Cubic	If Under 24 Hrs. Hours Min. 215 dispanic Origin? (Span, Mexican, Puerto	(Month, Da	10g. Citizen of	9. Birthpli Count	hry) N.C. Dd. Inside City Limi X.XYes 2 □ N
To the art and mental rygene. If then 27 is marked other than "natural", or items 23a or 28a-f ehow and other traumatic event. The Medical Examinar rusal be notified at to other traumatic event. The Medical Examinar rusal by Funeral Director.	5. Social Security Number 240-32-1790 Usual Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number 5519 Rubin Ave 11. Marital Status 1 Never Married 2 Marrie (Specify only highest Elementary/Secondary (0·12) 11th grade 17. Father's Name (First, Middle, L. Archie 19a. Informant's Name/Relationsh	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates: s Education grade completed) College (1-4or 5+ na	(In yrs. last birthda 88 Yrs. 10c. City, Town or Baltin	Months Days Location 10 C € 10f. Zip Code 212 3. Was Decedent of Highes, specify Cubin 1 Yes, Specify Cubin 1	Hours Min. 215 dispanic Origin? (Span, Mexican, Puerto	(Month, Da	10g. Citizen of 14. Ra	What Count	hry) N.C. Dd. Inside City Limi X.XYes 2 □ N
f them 27 to marked other than "natural", or items 23s or 28s-f show an other traumatic event, the Medical Exerciper traust be notified at on other traumatic event, the Medical Exerciper traust be notified at on To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number 5519 Rubin Ave 11. Marital Status 1 Never Married 2 Marrie (Specify only highest Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, L. Archie 19a. Informant's Name/Relationsh	12. Was Decedent E Armed Forces? 1 Yes 2 Xo If Yes, Give Year or Dates: s Education grade completed) College (1-4or 5+	10c. City, Town or Baltin	Location 10 C C 10f. Zip Code 212 3. Was Decedent of Highes, specify Cubin 1 Yes, 2 Mino 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2	215 dispanic Origin? (Sp an, Mexican, Puerto	O1 C	10g. Citizen of U . S	What Count	hry) N.C. Dd. Inside City Limi X.XYes 2 □ N
if Item 27 is marked other other traumatic event, To Be C	Usual Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number 5519 Rubin Ave 11. Marital Status 1 Never Married 2 Marrie (Specify only highest Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, L. Archie 19a. Informant's Name/Relationsh	12. Was Decedent E Armed Forces? 1 Yes 2 Xes 1 Yes, Give Year or Dates: s Education grade completed) College (1-4or 5+	Baltin	10f. Zip Code 212 3. Was Decedent of Fif Yes, specify Cubin 1 Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto	acifu Yas or No	10g. Citizen of U S	What Count	Dd. Inside City Limi XXYes 2 □ N
or other traumatic event.	MD NA 10e. Street and Number 5519 Rubin Ave 11. Marital Status 1 Never Married 2 Marrie **Widowed 4 Divorced 15. Decedent: (Specify only highest Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, L Archie 19a. Informant's Name/Relationsh	12. Was Decedent E Armed Forces? 1 Yes 2 Xes 1 Yes, Give Year or Dates: s Education grade completed) College (1-4or 5+	Baltin	10f. Zip Code 212 3. Was Decedent of Fif Yes, specify Cubin 1 Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	U . S	What Count	XXYes 2□N
or other traumatic event,	10e. Street and Number 5519 Rubin Ave 11. Marital Status 1 Never Married 2 Marrie 15. Decedent: (Specify only highest Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, L Archie 19a. Informant's Name/Relationsh	12. Was Decedent E Armed Forces? 1 Yes 2 Xes 1 Yes, Give Year or Dates: s Education grade completed) College (1-4or 5+	ver in U.S. 1:	10f. Zip Code 212 3. Was Decedent of Highest Processing Cubic 1 ☐ Yes 2 🖾 No	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	U . S	S.A.	try?
or other traumatic event,	11. Marital Status 1 Never Married 2 Marrie 1 Never Married 2 Marrie 15. Decedent: (Specify only highest Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, L. Archie 19a. Informant's Name/Relationsh	12. Was Decedent E Armed Forces? 1 Yes 2 Xes 1 Yes, Give Year or Dates: s Education grade completed) College (1-4or 5+	16a. Dec	212 3. Was Decedent of Fif Yes, specify Cubic 1 Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	U . S	S.A.	
or other traumatic event. To Be C	11. Marital Status 1 Never Married 2 Marrie 15. Decedent: (Specify only highest Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, L Archie 19a. Informant's Name/Relationsh	12. Was Decedent E Armed Forces? 1 Yes 2 Xes 1 Yes, Give Year or Dates: s Education grade completed) College (1-4or 5+	16a. Dec	3. Was Decedent of Fif Yes, specify Cubin 1 ☐ Yes 2 ☒ No Decedent's Usual Occur Cede	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	ce - America	n Indian
or other traumatic event. To Be C	1 Never Married 2 Marrie **X**Widowed 4 Divorced 15. Decedent: (Specify only highest Elementary/Secondary (0·12) 11th grade 17. Father's Name (First, Middle, L Archie 19a. Informant's Name/Relationsh	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: s Education grade completed) College (1-4or 5+	16a. Dec	If Yes, specify Cubing 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	ce - America	n Indian
To Be C	**XWidowed 4 Divorced 15. Decedent' (Specify only highest Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, L Archie 19a. Informant's Name/Relationsh	If Yes, Give Year or Dates: s Education grade completed) College (1-4or 5+	16a. Dec (Gi life	1 ☐ Yes 2 🔀 No				ick, White, e	
or other traumatic event, To Be C	15. Decedent' (Specify only highest Elementary/Secondary (0·12) 11th grade 17. Father's Name (First, Middle, L. Archie 19a. Informant's Name/Relationsh	s Education grade completed) College (1-4or 5+	·) (Gi	cedent's Usual Occur	-,,.		Speci		10.
or other traumatic event,	(Specify only highest Elementary/Secondary (0·12) 11th grade 17. Father's Name (First, Middle, L. Archie 19a. Informant's Name/Relationsh	college (1-4or 5+	·) (Gi	cedent's Usual Occup ve kind of work done DO NOT use retired			Speci		ack
or other traumatic event,	11th grade 17. Father's Name (First, Middle, L Archie 19a. Informant's Name/Relationsh	na	-)	DO NOT use retired	ation during most of work	ing	16b. Kind of E	Business/Indi	ustry
or other traumatic event. To Be C	17. Father's Name (First, Middle, L Archie 19a. Informant's Name/Relationsh		Ct				_		
or other traumatic e	Archie 19a. Informant's Name/Relationsh	ast)		stodial			Synac		
or other trau	19a. Informant's Name/Relationsh				18. Mother's Name			me)	
or other trau					Kattie				
: b	Annie Flowers			iling Address (Street					Code)
: b		-Daughter		.3 Highga			timore	e Md	21215
jury	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of Dis cemetery, ci	position (Name of rematory or other place	(8)	Date	20c. Location	- City or Tow	m, State
	'4 Donation 5 Other (Sp.	ecify)		n Cemete		/2004	Baltin	ore (Co, Md
mpor pnce	21. Signature of Funeral Service K	censee (22. Name and Address March F/		· · · · · · · · · · · · · · · · · · ·	Darcan	ione .	50, 11a
E 5 8	Nakau 13,	Joknson	1	4300 Wab	n west ash Ave	, Balt	imore	МВ	21215
	23a. Part1. Enter the disease, or c shock, or heart failure. List o	complications that caused the	he death. Do not e	inter the mode of dyin	g, such as cardiac o	or respiratory ar	rest,		Annenvimete
cian	Immediate Cause (Final	1	1	1 . /				2	Interval Between Onset and Death
ical	disease or condition resulting in death)	a. interce	consequence of):	hemons.	170				days
iner		1							,
e e	S quentially list conditions if any, leading to immediate	b. Due o or as a	consequence of):					- li	n Knows
m ir	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Tal-transit	resulting in death) Last	Due to (or as a	consequence of):						
ing in		d							
detached for use as the		0.							
letached for use as the Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					224 Da	te of delivery	
C a	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tii		☐Ectopic pregnancy ☐ Other (specify)				,	/ Day Year
rhec nysi	1 □ Yes 2 No 9 □ Unknown	9□ Unknown							
deta	Part II. Other significant condition	s contributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use conf	ribute to the	cause of death?
should be det	diahetes mi	ellites	-	, ,					oly 4 ⊠″Unknov
shou	-011	1.							7 7 30.1.6.101
CA CT	coronor arl	ery discas	e			24a. Was a autop:	sy	prior to comp	sy findings availab pletion of cause o
ga S						perfor 1 ☐ Yes		death? 1 ☐ Yes 2	No.
Be ector	25. Was case referred to medical examiner?	11			26. Place of Death	(Check only or	10)		
7 die	1 ☐ Yes 2 D No		2 ER/Outpatie		4 U Nursing Hor	ne 5 🗆 Resid	ence 6 🗆 Oth	er (Specify)	
led in by the funeral di	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Vate of Injury (Month, Day)	/eer) 28b. Time Injury		at 2	28d. Describe h	ow injury occur	red	
he n	2 Accident investiga				Yes 2 □ No				
tiffic	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of Injury building, etc.	/ - At home, farm, s	treet, factory, office	2	28f. Location (S City or Town	treet and Numb	er or Rural F	Route Number,
Se de						0.1, G. 7.0W.	n, olatoj		
completely filled in by the	29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, dea	th occurred at the tim	e, date and place, a	and due to the c	ause(s) and ma	inner as state	ed.
ompletely filled in by the funeral director, page Medical Certification; To Be Com	one)	caminer: On the basis of each manner state	xamination and/or i	nvestigation, in my op	pinion, death occurre	ed at the time, d	late and place,	and due to th	ie cause(s)
Σ	29b. Signature and title of certifier	7 15		29c. License	number	2	9d. Date signed	d (Month, Da	ıy, Year)
	- Chivy	A		PFS	a do it	d	FLL	>	2 post
	30. Name and ddress of person wi	no completed cause of dea	th (Item 23a) (Type	. Print)	7 4	7	1 Conha	vy -	7 2009
-	John Cras		ine I	Lancian III	4 300	A.			
T				V A LOT LAND TO THE REAL PROPERTY AND ADDRESS OF THE REAL PROPERTY	4	La r			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Z U 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yeer February **Physician** PM Richard Riley MacWatters 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kosedale Ballimore uare Hospital Center tranklin Si If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min 8. Date of Birth (Month, Day, Year) Jun 13, 19 9. Birthplece (State or Foreign Country)
Virginia 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2□ F 63 yrs. 534-36-1351 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Mudical Examiner must be notified at 1 Yes 2 No MD Harford Joppa Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 353 Blackburn Place United States or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 57 – 65 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Baltimore, Maryland 21215-0036 by 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Air National Guard s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 le marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Weapons Mechanic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lester Thomas MacWatters, Sr. Teel Reams ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 353 Blackburn Place, Joppa, MD 21085 Mrs. Danelle MacWatters/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or oth Feb 4 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licenses M00286 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -una /Medical Due to (or as a consequence of): **Examiner** Failure ACUT Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit or Attanding Physician: The law requires that the death certificate be executed JED. and Due to (or as a consequal ce of) the attending physicien Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yas 2 ☐ No. P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 ☐NO 3 ☐ Probably 4 ☐Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 Ho 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ih. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 02/01 Kes oooo 3 cause of death (Item 23a) (Type, Print) 30. Name and address of person who com 9000 Franklin Square Drive Baltimore Md 21237 lhandie Nyitenda MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State outes! FFB 0 4 2004 Registrar

MacWatters

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 8.9 per fn 8845 7-15-05 vt

	1	For State Registrar	State of	Maryland		irtmen tificate			and M		iene eg. No.	2004	02986
Physician	1	1. Decedent's Name (First, Middle, Last Barbara)	Ann		1	Meyeı	rs		2. Date of Deal Month Januar	Day	1,2004	3. Time of Death
/Medical Examiner		4a. Fecility Name (If not institution, give # 3 B Street	street and nun	nber)			Town, or I	Location o	of Death			County of Dee	
Funeral Director			х]м 2 X]F	7. Age (In yrs. la 75	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day)	Year)	9. Bir MD	thplace (State or Foreign buntry)
Maryland I-f ahow		Usuel Residence of Decedent 10a. State 10b. County MD Anne A	runde1		Town or Lo							-	10d. Inside City Limits
with the Mar	2	10e. Street and Number		'		10f. Zip	Code 21401			1		zen of What C	ountry?
be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other than "natural", or Itame 23e or 28e-f ahow avent, the Mudical Excultant has be notified at the Commission by Finneral Director.		#3 B Street 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	2 ∑ No ′e	1		ent of His	panic Ori	gin? (Spe , Puerto F	city Yes or No- Rican, etc.)		14. Race - Ame Black, Whi	
d 2 should be filed within 72 hours all the and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Examination of To Re Commissed that	nubleten	15. Decedent's Edu (Specify only highest grad		-4or 5+)	16a. Deced (Give life. L	kind of wor DO NOT us	l Occupat k done du e retired)	tion uring most	t of workir	ng		nd of Business	/Industry Credit
should be filed within and Mental Hygiene. marked other than imetic avent, the M	0	17. Father's Name (First, Middle, Last)								(First, Middle, I			
should nd Mer marks marks	2	Victor Meyers 19a. Informant's Name/Relationship (7)				_		nd Numbe	r or Rura	Haber		r Town, State,	Zip Code)
	-	Linda Real (Frie) 20a. Method of Disposition 1 □ Burial 2 ፟ Cremation 3 □ F			tr 3 E ice of Dispo metery, crem	sition (Nan	ne of)	D.		20c. Lo	cation - City or	
permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licen		Meti	ro Cre	Name and Harde	d Address	of Facilit Funer	/3/20 ^X al H	004 I lome P.A Annapo		imore,	
Physician /Medical		23a. Per1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	idations that cone cause on ea	aused the death. ach line. 4.857ve	Do not ent	er the mode	e of dying	, such as	cardiac or	r respiratory arre	est,	, MD 2.	Approximate Interval Between Onset and Death MOURS
tificate be executed with a support of the burial-transit as the burial-transit and a support of the burial-transit and the burial-transi	Cyallin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c	or as a conseque									
death cer a attendir d for use	ysicialivined	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live b	come of pregnandirth 2 Fetal cant at time of deapwn	death 3	Ectopic pro					2	23d. Date of de Month	livery Day Year
uires that the right by the right be detached by the right by the right by Physics		Part II. Other significant conditions co	ntributing to de	eath but not result	ting in the ur	nderlying ca	ause giver	n in Part I.		23e. Did tob			o the cause of death? robably 4 □Unknown
Physician: The law require this certificate has been signal director, page 2 should be completed.	on bien	Breast canc	er							24a. Was a autops perform	у .	24b. Were at prior to death?	utopsy findings available completion of cause of
Physician: The this certificate ral director, pag	0	25. Was case referred to medical examiner?	Hospital:	205	R/Outpatien	20.00	Other		of Death	(Check only on			-4.1
ding Afte fune		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation			28b. Time of Injury		Bc. Injury Work	at	2	8d. Describe ho		Other (Spe	City)
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After templetely filled in by the funeral Certification:	Sel tillico	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildin	of Injury - At hom ng, etc. (Specify)	ne, farm, str	eet, factory	, office		2	8f. Location (St. City or Town	reet and , State)	d Number or R	ural Route Number,
Hospi 4 hou Funer iely fill		29a. Certifier (Check only one) Certifying Phy Medical Exemi	sician: To the ner: On the ba and mann	asis of examination	ledge, death on and/or inv	occurred a restigation,	at the time in my opi	e, date an	d place, a th occurre	nd due to the ca d at the time, da	use(s) ate and	and manner as place, and due	s stated. to the cause(s)
To the within 2 To the complete		29b. Signature and title of antifier		u m	,D,	290	License D4	number 73/	1	29	9d. Date	signed (Mont	
		30. Name and address of person who con Suzanne W. Nieme					ue,	Annar	olis	, MD 21	401		- 11° 1
State Registrar		31. Date filed (Month, Day, Year)		egistrar's/Signatu			and a	p					

			1 - For State Registrar	State of N	faryland / De	•	ent of Heate of D		and N	Mental H	Hygie Reg.	-/11	04	02981
			Decedent's Name (First, Middle, La	st)						2. Date of				3. Time of Death
	Physici		Norman	Charle	S	Mel1	ing			Janua	rv	Day 28 2	Year 2004	2:00 a M
	/Medic Examin		4a. Facility Name (If not institution, give	re street and numbe	r)		ity, Town, or	Location	of Death			4c. County		
			Crofton Convale				Croft	on				Anne	Aruno	del
	Funeral		5. Social Security Number 6.5	Sex 7. A	Age (In yrs. last birtho		der 1 Year	If Under		8. Date of	Birth		9. Birthp	place (State or Foreign
	Director		212-01-4266	1 XM 2□F	93 Yr	s. Month	ns Days	Hours	Min.	Nov.	14,	1910	Mary	yland
	pu ,		Usual Residence of Decedent		10c. City, Town o	-1								od traids obstants
	aryla ahov	-	10a. State 10b. County	3 - 1									'	10d. Inside City Limits 1 ☐ Yes 2000
	Me M	ecto	MD Anne A	rundel	Seven		Zip Code				10-	. Citizen of \	M5-1 C	
	with t	급	10e. Street and Number			101.	21144				109.		VIIat Cour	itry r
	eath	eral	7936 Telegraph R	12. Was Deceder	nt Ever in II S	13 Was De		snanic Ori	nin? /Sr	ecify Yes or	No	USA 14. Bac	e - Americ	can Indian,
	ter d	Funeral Director	1 Never Married 2 Married	Armed Forces	5? 1 No	If Yes, s	pecify Cubar	n, Mexicar	, Puerto	Rican, etc.)	110		ck, White,	
336	urs af	þ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates	10/3-/5	1 🗌 Yes	2 X No	Specify:				Specify	/: Wh	nite
21215-0036	within 72 hours after death with the Maryland ene. than *neturel', or Items 23e or 28e-f ahow fra Medical Examiner must be notified at	Completed	15. Decedent's E	ducation	16a. D	ecedent's U	sual Occupa	ition	4 06		16	b. Kind of B	usiness/In	dustry
215	hin 7	ple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4o	`//		T use retired)		t OF WORK	ung				
2	ad wit	Con	6			hanic				##	S	hippi	ng	
5	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)						e (First, Mid	dle, Mai	den Suman	10)	,
yla	Ment Ment Arkec atic	2	Henry Melling					Emma						
Maryland	2 sho		19a. Informant's Name/Relationship							al Route Nu				Code)
	and lealth m 27		Norman Luzier (N	epnew)	20b. Place of D			n Koa		Evern				Caste
0	ges it of h		20a. Method of Disposition 1 X Burial 2 Cremation 3		e cemetery,	crematory o	or other place	1				c. Location -	_	
Baltimore,	rtmer rtmer rtant njury		' 4 □ Donation 5 □ Other (Speci	11-10-11-11-11-11-11-11-11-11-11-11-11-1	Marylar		-		/2/2		_	ownsv	ille,	, MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "neturel", or items 23s or 28s-f ahow emportant: in Item 27 is marked other than "neturel", or items 23s or 28s-f ahow injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Lice	% —						Home,			D 214	4 01
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caus	ed the death. Do not line.	enter the n	node of dying	, such as	cardiac	or respirator	y arrest			Approximate Interval Between
	Physician		Immediete Cause (Final disease or condition	Corners	itino H	hout	-6	Luni	į.					Onset and Death
Sec.	/Medical Examiner		resulting in death)	Dur To/ or a	is a consequence of)		(/	-						
	LAMITIMES	L	Sequentially list conditions,	b										···-
	ed sit	lne	cause. Enter Underlying Cause (Disease or injury	Due to [or a	is a consequence of									
	and and	хап	that initiated events resulting in death) Last	c. Due to (or a	is a consequence of)								-+	
8760,	eath certificate be executed attending physicien and for use as the burial-transit	dical Examiner	l l	,										
687	ficate phys	g		_ d										
Вох	nding use a	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy	- 0-						23d. Dat	te of delive	эгу
m	death certific e attending p id for use as	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	2 Fetal death at time of death	3 ☐ Ectopic 5 ☐ Other	(specify)				_	Mo	nth	Day Year
Ö	that the de ad by the detached	hys	9 Unknown	9□ Unknown										
S, D	The law requires thet the tite has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions	contributing to death	but not resulting in the	ne underlyin	g cause give	n in Part I.		23e. D	id tobac	co use cont	ribute to th	ne cause of death?
ğ	w require been signatured should b									1	☐ Yes	2 DM0	3 Prob	ably 4 Unknown
Vital Record	e law re has be je 2 sho	Completed	_							24a. W	has an	24b. \	Nere auto	psy findings available mpletion of cause of
ď	The la	mo;									emorme	1?	death?	2 X No
ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place	of Deat	h (Check on				
	S D	To	1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/Outp	atient 3	DOA Othe	1. 4 Nu Nu	rsing Ho	ome 5 R	esidenc	e 6 Oth	er (Specif)	y)
n of	ng Ph fter th ineral	:io	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Tin Day Yeer) 1nju	ıry	28c. Injury Work	at		28d. Descri				
Sio	Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be			М		′es 2 🔲 i	No					
Division	Dir	Certification:	4 Homicide determined	286. Place of I	njury - At home, farm etc. (Specify)	, street, fac	tory, office				n (Stree Town, S		er or Rura	d Route Number,
	spital ours narel filled		29a. Certifier 1 V Certifying P	nysician: To the bes	st of my knowledge, o	leath occurr	ed at the time	e. date an	d place.	and due to t	he caus	e(s) and ma	nner as si	ated
	e Hos 24 h e Fur letely	edical	(Check only 2 Medical Exa	miner: On the basis and manner:	of examination and/o	or investigat	ion, in my op	inion, dea	th occur	red at the tin	ne, date	and place,	and due to	the cause(s)
	To the Hospitel within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of certifier				29c. License	number			29d.	Date signed	J (Month,	Dey, Year)
			D-1/1	N	10		03/	895	8		1	/301	12001	4
	V		30. Name and address of person who	completed cause of	tleath (Item 23a) (Ty	pe, Print)		-						21113
			Daliet Sy	The Sich	hu MD	14/3	ANAL	APOL	13	ROAL	7	406	ODE	NTON MO
	Sta		31. Date filed Month, Day, Year	2004 32. Red	trar's Signature	100	Ser.							
	Registr	ar	E bull		-	Co Paris								

			1 - For State Registrar	State of Maryland	d / Dep <i>Ce</i>	artment of Healt rtificate of Dea	in and Men I <i>th</i>	ital Hyglene Reg. No	CU114	02982
		119	Decedent's Name (First, Middle, Last)					Date of Death		3. Time of Death
	Physici		2417 1.203	2/10/2 71	\cap		-	Month Da	^	7:40 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Locat		1. 10 17 10	County of Death	
	LAMINI	161	803 WALTERS M	1.11 RDAD		FORSE	1114		HAREDRI	
	Funeral		5. Social Security Number 6. Sex	11000	last birthday		nder 24 Hrs. 8. (Date of Birth	9. Birthpla	ace (State or Foreign
	Director		als 32 4350 X	M 2DF 70	Yrs.	Months Days Hou	urs Min.	Month, Day, Year,	33 Kani	35 KY
Mari	D		Usual Residence of Decedent					1		
	how		10a. State 10b. County	10c. City	y, Town or L	ocation			10	d. Inside City Limits
	a Ma	cto	MARILAD HARFOL	30	FORS	LIKTE				1 Tyes 2 No
	or 28	Director	10e. Street and Number	Ø= . ○		10f. Zip Code		10g. Ci	tizen of What Count	ry?
	23a		803 WALIER	3 1 177 1606	40	2105	0		D.S.A.	
	ems erro	Funeral		12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hispania If Yes, specify Cuban, Mex	o Origin? (Specify xican, Puerto Rica	Yes or No- n, etc.)	14. Race - America Black, White, e	
9	or It		1 Never Married 25 Married	TYSYes 2 No If Yes, Give \		1 Yes 250 No Spe	cify:		Specify: \ 7\1	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f show with the Medical Examinar must be redified at	Completed by	3 Widowed 4 Divorced	Year or Dates: KO					WH	115
Ϋ́	nat adice	lete	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	edent's Usual Occupation which is kind of work done during DO NOT use retired)	most of working	16b. K	(ind of Business/Indi	ustry
12	Mithir noe. than	E D	Elementary/Secondary (0-12)	College (1-4or 5+)	60	Q DO TO		6	2110230	0.00
	Hygie Hygie ther nt, II	ပိ	17. Father's Name (First, Middle, Last)		7-17	18 M	other's Name (Fin	rst, Middle, Maider	Sumame)	.110.1
ä	ntal h	Be				(7-000	. P. A.	11.70.	
Ë	should ind Men ind marke umatic	유	19a. Informant's Name/Relationship (Ty	Jacobs Printl	10h Mail	ing Address (Street and Nu	IZICIZ	LA LIMBOS Cibe	or Town State Zin	Code (abo
Maryland	and 2 sl ealth an n 27 is r nar traur		19a. Illiomants Namer Helationship (7)	pe, rinky	So. Wall	ing Address (Street and IVE	CT 1 C.	and validati, city	or rown, state, zip	Charles
	1 and Healt em 2 ther	1.5	20a. Method of Disposition	20b. Pl	lace of Disp	osition (Name of	Date	20c. L	ocation - City or Tow	m. State
چ	Pages nent of int: If its iry or o		1 ☐ Burial ZZ Cremation 3 ☐ P	Removal from State	emetery cre	matory or other place)	FIB. 2	_	0	Man o
Baltimore,	그 든 원 글	l s	¹ Donation 5 ☐ Other (Specify) 21. Sona Tre 1 Luner Service Licens		retti	2. Name and Address of F	7007	1 10	771917	MARILARY
Ba	Department of the permit of th		21. Schame Tuliera Selvice Cells	7	5	LAND FUNG	JT C7/063	T- BATE	11 . 17	â1050
			23a. Part1. Enter the disease, or compl	ications that caused the death	Do not en	tor the mode of duing such	DISIAS	1015719	177 11861	Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne chuse on each line.	. 50 1101 01	iter the mode or dying, such	i as cardiac or rec	spiratory arrest,		interval Between
						1	1	-		Onset and Death
1	Physician (Modical		disease or condition	Myoca	andi	al Infav	ction	(xc		Onset and Death
	/Medical Examiner			a. Due to (or as a consequ	uence of):	al Infan	ction	(xc		Onset and Death
	/Medical	j.	disease or condition resulting in death) Sequentially list conditions,	,		al Infan	ction	(xc		Onset and Death
VV	/Medical Examiner	niner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1		al Infav	ction	(xc		Onset and Death
100	/Medical Examiner		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	uanca of).	al Infav	ction	(xc		Onset and Death
100	/Medical Examiner	Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events	b. Due to (or as a conseque	uanca of).	al Infav	ction	_ (xc		Onset and Death 2.1.1. h OUV
8760,	/Medical Examiner bbhysicien and the burial-transil	dlcal Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events	b. Due to (or as a conseque	uanca of).	al Infav	ction	(xc		Onset and Death
68760,	/Medical Examiner bbhysicien and the burial-transil	edical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as a conseque	uanca of).	al Infav	ction	(*0	ute) F	en hours
Box 68760, ≨	/Medical Examiner bbhysicien and the burial-transil	edical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths?	Due to (or as a consequence) Due to (or as a consequence) 32. If yes, outcome of pregnants of the present of	uance of): uence of): incy	Ectopic pregnancy	ction	(**	ute) T	en hours
Box 68760, ≨	/Medical Examiner bbhysicien and the burial-transil	edical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	b. Due to (or as a consequence) Due to (or as a consequence) 3.3c. If yes, outcome of pregnare	uance of): uence of): incy	□Ectopic pregnancy □Other (specify)	ctien	(xc	ute) T	en hours
P.O. Box 68760,	/Medical Examiner bbhysicien and the burial-transil	Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ ∀es 2 ②No	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): uence of): uence of): ancy death 3 eath 5	Other (specify)	etien	23e. Did tobacco	ute) T	y Day Year
P.O. Box 68760,	/Medical Examiner bbhysicien and the burial-transil	by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): uence of): uence of): ancy death 3 eath 5	Other (specify)	ction		23d. Date of deliver Month	y Day Year
P.O. Box 68760,	/Medical Examiner bbhysicien and the burial-transil	by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): uence of): uence of): ancy death 3 eath 5	Other (specify)	etien	1 ☐ Yes 2	23d. Date of delivery Month use contribute to the	y Year o cause of death? bly 4 □Unknown
P.O. Box 68760,	e law requires that the death certificate be executed and has been signed by the attending physician and has been signed by the attending physician and has been signed by the attending physician and has been signed by the attending physician and has been signed by the attending physician and has been signed by the attending physician and has been signed by the attending physician and has been signed by the attending physician and physician and has been signed by the attending physician and physician a	by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): uence of): uence of): ancy death 3 eath 5	Other (specify)	etien		23d. Date of deliver Month use contribute to the No 3 Proba	y Year cause of death? bly 4 □Unknown sy findings available pletion of cause of
P.O. Box 68760,	The law requires that the death certificate be executed as the law requires that has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of): uence of): uence of): ancy death 3 eath 5	Other (specify)		1 Yes 2 24a. Was an autopsy performed? 1 Yes 25 No	23d. Date of deliver Month use contribute to the No 3 Proba 24b. Were autoprior to compleath?	y Year cause of death? bly 4 □Unknown sy findings available
Vital Records, P.O. Box 68760,	The law requires that the death certificate be executed as the law requires that has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 2 No 9 Unknown Part II. Other significant conditions conditions conditions conditions conditions are referred to medical examiner?	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown Intributing to death but not resure the sequence of the sequence	uence of): uence	Other (specify)	Place of Death (Ct	1 Yes 2 24a. Was an autopsy performed? 1 Yes 258 Noteck only one)	23d. Date of delivery Month use contribute to the No 3 Proba 24b. Were autoport to come death? 1 Yes 2	y Year cause of death? bly 4 □Unknown sy findings available pletion of cause of
Vital Records, P.O. Box 68760,	The law requires that the death certificate be executed as the law requires that has been signed by the attending physician and page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 2 No 9 Unknown Part II. Other significant conditions con	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnant a lime of de good unknown. Due to (or as a consequence.) Due to (or as a consequence.) All yes, outcome of pregnant a lime of de good unknown. Due to (or as a consequence.) All yes, outcome of pregnant a lime of de good unknown. Due to (or as a consequence.) Due to (or as a consequence.) Due to (or as a consequence.) Due to (or as a consequence.) Due to (or as a consequence.) Due to (or as a consequence.) Due to (or as a consequence.) Due to (or as a consequence.)	uence of): uence of): uence of): uence of): ancy death 3 eath 5	Other (specify) underlying cause given in P CA SC 26. F ant 3 DOA Other: 4 Control 28c. Injury at	Place of Death (Cf	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 Note that the second of	23d. Date of delivery Month use contribute to the No 3 Proba 24b. Were autoport to come death? 1 Yes 2	y Year cause of death? bly 4 □Unknown sy findings available pletion of cause of
Vital Records, P.O. Box 68760,	The law requires that the death certificate be executed as the law requires that has been signed by the attending physician and page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown Intributing to death but not resure the sequence of the sequence	uence of): uence	Other (specify) underlying cause given in P QQ SC 26. F nt. 3 DOA Other: 4	Place of Death (Cr.	1 Yes 2 24a. Was an autopsy performed? 1 Yes 258 Noteck only one)	23d. Date of delivery Month use contribute to the No 3 Proba 24b. Were autoport to come death? 1 Yes 2	y Year cause of death? bly 4 □Unknown sy findings available pletion of cause of
Vital Records, P.O. Box 68760,	The law requires that the death certificate be executed as the law requires that has been signed by the attending physician and page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnant at time of dealth but not resund the second of th	uence of): uence of): uence of): death 3 eath 5 ER/Outpatie 28b. Time 6 Injury	Other (specify) underlying cause given in P 26. F nt 3 DOA Other: 4 of 28c. Injury at Work? M 1 Yes:	Place of Death (Cf. Nursing Home 28d.	1 Yes 2 24a. Was an autopsy performed? 1 Yes ZANo neck only one) Residence Describe how inju	23d. Date of delivery Month use contribute to the No 3 Proba 24b. Were autoport to come death? 1 Yes 2	y Year cause of death? bly 4 □Unknown sy findings available pletion of cause of
P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the death. If death. Director: After this certificate has been signed by the attending physician and principle to the funeral director, page 2 should be detached for use as the burial-transit or principle.	To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 2 No 9 Unknown Part II. Other significant conditions conditions conditions conditions are referred to medical examiner? 1 Yes \$\mathbb{E}\$ No No 1.5 25. Was case referred to medical examiner? 1 Yes \$\mathbb{E}\$ No No 1.5 26. Manner of Death Pending 1.5 Pending 2 Accident 1.5 Pending	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnare 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown Intributing to death but not resure the second of the	uence of): uence of): uence of): death 3 eath 5 ER/Outpatie 28b. Time 6 Injury	Other (specify) underlying cause given in P 26. F nt 3 DOA Other: 4 of 28c. Injury at Work? M 1 Yes:	Place of Death (CF) Nursing Home 28d. 2 □ No	1 Yes 2 24a. Was an autopsy performed? 1 Yes ZANo neck only one) Residence Describe how inju	23d. Date of deliver Month use contribute to the No 3 Proba 24b. Were autoprior to com death? 1 Yes 2 6 Other (Specify) ry occurred	y Year cause of death? bly 4 □Unknown sy findings available pletion of cause of
Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the death. If death. Director: After this certificate has been signed by the attending physician and price the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown Intributing to death but not resure the second of the s	uence of): uence of): uence of): uence of): death 3i eath 5i utting in the eath 5i ER/Outpatie 28b. Time eath injury wence of):	Other (specify) underlying cause given in P 26. F at 3 DOA Other: 4 of 28c. Injury at Work? M 1 Yes treet, factory, office	Place of Death (Cf. Nursing Home 28d. 2 \(\text{No} \)	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 No neck only one) Residence Describe how inju Location (Street an City or Town, State	23d. Date of deliver Month use contribute to the No 3 Proba 24b. Were autopprior to comdeath? 1 Ves 2 6 Other (Specify) ry occurred	y Year o cause of death? bly 4 Unknown sy findings available pletion of cause of Route Number,
Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the death. If death. Director: After this certificate has been signed by the attending physician and price the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnant at time of dealth but not resure to the sum of the	uence of): uence of): uence of): uence of): death 3i eath 5i utting in the eath 5i ER/Outpatie 28b. Time eath injury wence of):	Other (specify) underlying cause given in P 26. F at 3 DOA Other: 4 of 28c. Injury at Work? M 1 Yes treet, factory, office	Place of Death (Cf. Nursing Home 28d. 2 \(\text{No} \)	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 No neck only one) Residence Describe how inju Location (Street an City or Town, State	23d. Date of deliver Month use contribute to the No 3 Proba 24b. Were autopprior to comdeath? 1 Ves 2 6 Other (Specify) ry occurred	y Year o cause of death? bly 4 Unknown sy findings available pletion of cause of Route Number,
Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the death. If death. Director: After this certificate has been signed by the attending physician and price the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnant at lime of de 9 Unknown Introducting to death but not result of the second o	uence of): uence of): uence of): uence of): death 3i eath 5i utting in the eath 5i ER/Outpatie 28b. Time eath injury wence of):	Other (specify) underlying cause given in P 26. F at 3 DOA Other: 4 of 28c. Injury at Work? M 1 Yes treet, factory, office	Place of Death (Cf. 28d. 2 \(\text{No} \) No 28f. e and place, and death occurred a	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 Note to the ck only one) Residence Describe how inju Location (Street ar City or Town, State due to the cause(st the time, date and	23d. Date of deliver Month use contribute to the No 3 Proba 24b. Were autopprior to comdeath? 1 Ves 2 6 Other (Specify) ry occurred	y Year o cause of death? bly 4 □Unknown sy findings available pletion of cause of Route Number, ted. he cause(s)
Vital Records, P.O. Box 68760,	Attending Physician: The law requires that the death certificate be executed by the artending Physician and sector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit as a page.	edical Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions are referred to medical examiner? 1 Yes 2 No No No No No No No	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnant at lime of de 9 Unknown Introducting to death but not result of the second o	uence of): uence of): uence of): uence of): death 3i eath 5i utting in the eath 5i ER/Outpatie 28b. Time eath injury wence of):	Other (specify) underlying cause given in P 26. F nt 3 DOA Other: 4 of 28c. Injury at Work? M 28c. Injury at Work? I Yes street, factory, office	Place of Death (Cf. 28d. 2 \(\text{No} \) No 28f. e and place, and death occurred a	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 Note to the ck only one) Residence Describe how inju Location (Street ar City or Town, State due to the cause(st the time, date and	23d. Date of deliver Month use contribute to the No 3 Proba 24b. Were autoprior to com death? 1 Ves 2 6 Other (Specify) ry occurred and Number or Rural and number as sta diplace, and due to the	y Year o cause of death? bly 4 □Unknown sy findings available pletion of cause of Route Number, ted. he cause(s)
Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the death. If death. Director: After this certificate has been signed by the attending physician and price the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	edical Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions are referred to medical examiner? 1 Yes 2 No No No No No No No	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnant at time of de 9 Unknown Introducting to death but not result of the second o	uence of): uence of): uence of): incy i death 3i eath 5i eath 5i eath 5i eath 5i wilding in the of injury eme, farm, si v) wiledge, death and/or in	Other (specify) underlying cause given in P 26. F nt 3 DOA Other: 4 Work? M 28c. Injury at Work? I Yes th occurred at the time, dat nestigation, in my opinion, 29c. License numb	Place of Death (Cf. 28d. 2 \(\text{No} \) No 28f. e and place, and death occurred a	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 Note to the ck only one) Residence Describe how inju Location (Street ar City or Town, State due to the cause(st the time, date and	23d. Date of deliver Month use contribute to the No 3 Proba 24b. Were autoperior to composite to the death? 1 Yes 2 6 Other (Specify) ry occurred and Number or Rural and number as stated place, and due to the state of t	y Year o cause of death? bly 4 □Unknown sy findings available pletion of cause of Route Number, ted. he cause(s)
Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the death. If death. Director: After this certificate has been signed by the attending physician and price the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	edical Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnant at time of de 9 Unknown Introducting to death but not result of the second o	uence of): uence of): uence of): incy i death 3i eath 5i eath 5i eath 5i eath 5i wilding in the of injury eme, farm, si v) wiledge, death and/or in	Other (specify) underlying cause given in P 26. F nt 3 DOA Other: 4 Work? M 28c. Injury at Work? I Yes th occurred at the time, dat nestigation, in my opinion, 29c. License numb	Place of Death (Cf. 28d. 2 \(\text{No} \) No 28f. e and place, and death occurred a	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 Note to the ck only one) Residence Describe how inju Location (Street ar City or Town, State due to the cause(st the time, date and	23d. Date of deliver Month use contribute to the No 3 Proba 24b. Were autoperior to composite to the death? 1 Yes 2 6 Other (Specify) ry occurred and Number or Rural and number as stated place, and due to the state of t	y Year o cause of death? bly 4 □Unknown sy findings available pletion of cause of Route Number, ted. he cause(s)
Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	Due to (or as a consequence. Due to (or as a consequence. 23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown Intributing to death but not resure the second of the s	uence of): uence of): uence of): uence of): uence of): death 3 i eath 5 i utting in the case of	Other (specify) underlying cause given in P 26. F nt 3 DOA Other: 4 Work? M 28c. Injury at Work? I Yes th occurred at the time, dat nestigation, in my opinion, 29c. License numb	Place of Death (Cf. 28d. 2 \(\text{No} \) No 28f. e and place, and death occurred a	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 Note to the ck only one) Residence Describe how inju Location (Street ar City or Town, State due to the cause(st the time, date and	23d. Date of deliver Month use contribute to the No 3 Proba 24b. Were autoperior to composite to the death? 1 Yes 2 6 Other (Specify) ry occurred and Number or Rural and number as stated place, and due to the state of t	y Year o cause of death? bly 4 □Unknown sy findings available pletion of cause of Route Number, ted. he cause(s)

3. Time of Death

0925

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

4 Unknown

Day

XX Yes 2 □ No

Physician	
/Medical	
Examiner	

Funeral Director

with the Maryland r 28a-f show item 27 is marked other than "natural", or Items 23a or other traumatic event. It a Medical Examiner must be

permit. Pages 1
Department of H
Important: If ite
any injury or ot Physician /Medical **Examiner**

KUTH MARSHAL

death certificate be executed the attending physician and hed for use as the burial-transit detached signed by page 2 should be has been certificate funeral dir

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice filled in by

Director þ Completed Be Examine Physician/Medical Š Completed Be Certification: To 2 Accident

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 28, MARSHALL 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth WOODWARD ESTATES BOWIE PRINCE GEORGE 8. Date of Birth (Month, Day, Year 2/12/1908 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ XFX 022-18-2020 95 MA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location PRINCE GEORGES BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14997 HEALTH CARE CENTER DRIVE 20716 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes ŽŽŽNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOSTESS EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FREDERICK HAMILTO ELIZABETH KEOUGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD MARSHALL - SON 12114 FORGE LANE, BOWIE, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XX urial 2 Cremation 3 XX memoval from State * 4 ☐ Donation 5 ☐ Other (Specify) AURBURN CEM. 2/3/04 CAMBRIDGE, MA 21. Signature of Juneral Service Licenses | KELLY GREGORY FINK # MUII48 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061 23a. Part. Enter the dise. e, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Chise (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 \(\text{Yes} \) 2XX\(\text{No} \) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2020No 1 ☐ Yes 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Whether (Specify) examiner' 2 ER/Outpatient 3 DOA

25. Was case referred to medical Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐XNo 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of

5 Pending

investigation 6 Could not be determined

4 T Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause is and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated and manner stated.

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) JANUARY 29, 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

D0054689 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 201

JAMES WANG, MD 14999 HEALTH CENTER DRIVE, BOWIE MARYLAND 20716

31. Date filed (Month, Day, Year) State FEB U & ZUU4 Registrar

3 ☐ Suicide

(Check only

29b. Signature and title of certifier

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

			For State Registrar	State of Maryla		artment o			ind M		giene 2	004	02984
I	Physici	an	Decedent's Name (First, Middle, Last) CHARLOTTE J • MA	CGILL						2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give stre ROLAND PARK PLAC	et and number)		4b. City, To			f Death	Sariari	4c. Cou	inty of Deeth	11:30 PM
8	Funeral Director	×	5. Social Security Number 6. Sex 157-58-5618	7. Age (In y 9 4	rs. last birthday) Yrs.	If Under 1 ' Months E	Year Days	If Under 2 Hours	Min.	8. Date of Birtl Month, Dey 10/01/	1909	Cou	place (State or Foreign ntry) YLAND
	e Maryland Ba-f show	ctor	10a. State 10b. County MD N/A	10c.	City, Town or Lo								10d. Inside City Limits 1 X Yes 2 □ No
	with the Sa or 2.	Dire	10e. Street and Number 830 WEST 40TH ST	REET		10f. Zip Co	ode 211				10g. Citizen USA	of What Cou	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Intropretant: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event. Its Madical Extribition trains the notified at once.	by Funeral Director		Was Decedent Ever in Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:			t of His Cuban	panic Orig , Mexican Specify:	jin? (Spe , Puerto I	city Yes or No- Rican, etc.)	14. F	Race - Amen Black, White, Icify: WHI	etc.
21215-0036	within 72 ho iene. • then *natur ihe Medical	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 1 2 Y R S		(Give	dent's Usual C kind of work of DO NOT use i	done du retired)	ion i <i>ring</i> most	of workii	ng		f Business/Ir	•
Maryland 2	ould be filed Mental Hygi tarked other tatic event.	To Be C	17. Father's Name (First, Middle, Last) THOMAS JOHNSON					СНА	RLO	(First, Middle,	Maiden Sun YO	name)	
Mar	and 2 sh alith and 127 is m or traum		19a. Informant's Name/Relationship (Type, RICHARD MACGILL	(SON)						• TOWS			
Baltimore,	ages 1 and of He and of He it it item y or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Place of Dispo cemetery, cren	natory or othe	r place,					on - City or To	own, Stete CITY, MD.
Baltir	permit. P Departme Importar any injur		21. Signature of Europal Service Licensee	(II)	22 H I	Name and A	ddress	of Facility JENK	INS	& SON	s co.		
	Physician / Medical physician and physician and the prijat-transit	dical Examiner	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of trimediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	ause on each line.	equence of):	die	ae	such as c			est,		Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed ten has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ™No 9 ☐ Unknown	If yes, outcome of prec 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	ital death 3 □	Ectopic pregr Other (specif						Date of delive	ary Day Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions contrib	uting to death but not r	esulting in the ur	nderlying caus	e given	in Part I.			pacco use co		ne cause of death?
		Completed by								24a. Was a autops perform	v -	prior to coi death?	psy findings available appletion of cause of
Z I	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hosp	oital: 1 Inpatient 2	7500-4-4	2 7 7 7 7 7	Other:			(Check only on			
Division of	ding After	-		28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c.	Injury a Work?	4 Nurs	2	e 5 Reside Bd. Describe ho			1)
Divis	tal or Atten	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	eet, factory, of	fice		2	Bf. Location (St City or Town	reet and Nur , State)	mber or Rura	l Route Number,
(To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	an: To the best of my k On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the estigation, in	ne time, my opin	date and nion, death	place, a	nd due to the ca d at the time, da	use(s) and a ate and place	manner as st e, and due to	ated. the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	acreso	c no	29c. Li				2	9d. Date sign	ned (Month, i	Day, Year)
	V		30. Name and address of person who comp			Print)					TYVYA	V 31	1 COOX
	Sta Registr		ISABELLE MCGREGO: 31. Date filed (Month, Day, Year)	R M.D. 83	Q. W. 4	OTH S	T.	BAL	го.,	MD. 2	1211.		

			For State Registrar	State of	Maryland / Depa	artment of H			ene 2001	. 02985	
90			1. Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death	
M	Physici		Doris Ruth Mac	Pherson				January	30, 2004	4:30 AM M	
7	/Medic Examir		4a. Facility Name (If not institution, giv	e street and numb	per)	4b. City, Town, or	Location of Death	, Journal J	4c. County of Dec	eth	
	Karangan Karangan		Gilchrist Cente	r @ GBMC		Towson	1		Baltir	ore	
	Funeral		5. Social Security Number 6. S		Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	O B	thplace (State or Foreign ountry)	
da in	Director		218-07-0206	☐M 2XIF	85 Yrs.	Months Days	Hours Min.	May 2, 1	918 Ma	aryland	
	p ,		Usual Residence of Decedent		10.00						
	anylan ehow	L	10a. State 10b. County	_	10c. City, Town or Lo					10d. Inside City Limits	
	8a-1	cto	Maryland Harfor	d	Bel Air					1 ☐ Yes 21X No	
	or 2	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	ountry?	
	ath w	Funerai	900 Mitchum Cou			21014			USA		
	e me	Tue	11. Marital Status	12. Was Deced Armed Forc		Was Decedent of Hill If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
36	or h	by Fi	1 Never Married 2 Married	1 🗌 Yes 2 If Yes, Give		1 Yes 2 No	Specity:		Specify:		
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Exartirar must be rotified at	D D	3 Widowed 4 □ Divorced	Year or Date						White	
5	"nat	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occupa kind of work done d DO NOT use retired;	ation <i>furing</i> most of work	ing 16	ib. Kind of Business	/Industry	
7	within and the man	шĔ	Elementary/Secondary (0-12)	College (1-4	or 5+)	emaker	,		○ II		
	Hygin ther		17. Father's Name (First, Middle, Last)		IICI	enaker	18 Mother's Nam	e (First, Middle, Ma	Own Home		
Maryland	12 should be filed within h and Mental Hygiene. 7 ie marked other than "fraumatic event, the Mes) Be	John Koy McIve				Martie				
2	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic	우	19a. Informant's Name/Relationship (19h Mailir	ng Address (Street a				Zin Cada)	
∑	d 2 s th ar th ar trau			•						21p 00de)	
Ġ,	of Health of Health item 27 i		Michael D. MacPhe 20a. Method of Disposition	erson /_	20b. Place of Dispo	Mitchum C sition (Name of			LUL ^u c. Location - City or	Town State	
٥	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐		Hilltop So	natory or other place		_			
Baltimore,	permit. Pag Depertment Important: I any injury o		*4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licery			m		04	owson, Ma	TYTANG	
Ba	permit. Pag Depertment Important: I any injury o		Ital 1	h. a de	-1	viccomas F	ùneral Ho	ome, P.A.	_		
			23a. Pert1. Enter the disease, or com	plications that cau	sed the death. Do not ent	1317 Coke	sbury Roa	ad, Abing	don, Mary	land 21009	
			shock, or heart failure. List only Immediate Cause (Final	one cause on eac	th line.	er the mode or dying	g, such as cardiac	or respiratory arrest	,	Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a)	chility					y cars	
	Examiner		f	Due to (or	as a consequence of):	/L	01.			~	
		<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	ted nsit	Ę	cause. Enter Underlying Cause (Disease or injury	240 10 (01	25 2 5 2 50 4 50 100 017.						
	xecu and al-tra	Examine	that initiated events resulting in death) Last	C. Due to (or	as a consequence of):				-		
8760,	cate be executed physicien and the burial-transit	ä			,						
687	phys s the	edicai		. d						***************************************	
×	eath certific attending p	/We	IF FEMALE:	23c. If yes, outco	me of pregnancy		1152		22d Date of de		
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birti	n 2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year	
0	the d	Physician/M	1 ☐ Yes 2 ☐No 9 ☐ Unknown	9 Unknow			1		:		
٥.	that the de led by the detached		Part II. Other significant conditions of	ontributing to dear	th but not resulting in the ur	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?	
Vital Records,	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	d by	Dementia	Cosi)			1 ☐ Yes	2 30No 3 □ Pi	obably 4 🗀 Unknown	
Ö	w require been si should t	iete						24a. Was an	24h Wasa a	denni findinalabli	
Re	The lavate has	ompleted			· · · · · · · · · · · · · · · · · · ·			autopsy performe	prior to	utopsy findings available completion of cause of	
<u>a</u>		O	25. Was case referred to medical					1 Yes 2		2 No	
₹		o Be	examiner?	Hospital:	• • • • • • • • • • • • • • • • • • •	Other		(Check only one)	\	1	
ō	Phys rthis ral di		27. Manner of Death	1 Inp	Injury 28b. Time of	3LI DOA	4 Li Nursing Ho	me 5 Residence 28d. Describe how	inium occurred	city/ respect	
Division	Attending r death.	ţ	Natural 5 Pending investigation	(Month,	Day Year) Injury	28c. Injury Work' M 1 □ Y	? 'es 2 □ No		injury occurred		
isi	Attendi death. ctor: A y the fu	fica	3 Suicide 6 Could not be		Injury - At home, farm, stre			28f. Location (Stree	at and Number or Ru	ıral Route Number	
ē	al or Attend after death Director: / d in by the f	Certification:	4 Homicide	building	, etc. (Specify)	7, 5,100		City or Town, S			
. 1	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier Certifying Ph	ysician: To the b	est of my knowledge, death	occurred at the time	e, date and place	and due to the caus	se(s) and manner as	stated	
X	ne Ha 24 } ie Fu	edical	(Check only 2 Medical Exam	niner: On the basi and manner	s or examination and/or inv	estigation, in my opi	inion, death occurr	ed at the time, date	and place, and due	to the cause(s)	
,	To the within 2 To the complet	Me	29b. Signature and title of certifier	0		29c. License	number		Date signed (Mont		
7			1 Allra	X_		1) 5	303	174	anuary 30	2004	
	di		30 Name and address of person who	completed cause	of death (Item 23a) (Type, I						
	\		Acron J. Cinaples	(SOO) (0	V. Cheelos S	it Dalter	noe no	21200			
	Sta	te	31. Date filed (Month, Dey, Year)	82. Reg	istrar's Signature	parker					
	Registr	ar	FFB 0 4 2004	THE THE	Last 1/2	75.5					

MACPHERSON, DORIS 1/30104 430M

			1 - For State Registrar	State of Maryland	•	artment of H			iene _{9. No.} 2001	02986
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medio		Norman H. Meyer	s, Sr.				Januar	y 31, 2004	
	Examir		4a. Fecility Name (If not institution, give s			4b. City, Town, or	Location of I	Death	4c. County of Deat	
			1980 Chipper Driv 5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthday)	Edge If Under 1 Year	WOOD If Under 24	Hrs. 8. Date of Birth	Harfor	
	Funeral Director		219-05-6923	M 2□F 82	Yrs.	Months Days		Min. (Month, Day, June 10.	Year) Co	hplace (State or Foreign juntry) arvland
			Usual Residence of Decedent					pane 10	1321 110	
	72 hours after death with the Maryland natural', or flams 23a or 28e-f show alsal Examiner mat be meithed at		10a. State 10b. County	10c. City, 1	Town or Lo	cation				10d. tnside City Limits 1 ☐ Yes 2 No
	8f.	cto	Maryland Harfor	d Co.	Ede	gewood			0	<u></u>
	with the	급	10e. Street and Number 1980 Chipper Driv	10		10f. Zip Code	21040		0g. Citizen of What Co	•
	urs after death with the Marylan el', or items 23a or 28e-f show Examiner i ust be mutified at	Funeral Director		Was Decedent Ever in U.S.	13. V	Was Decedent of Hi	21040 ispanic Origin) n? (Specify Yes or No- Puerto Rican, etc.)	United 14. Race - Ame	nican Indian,
(0	r han	Fun	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☑AYes 2 ☐ No				Puerto Rican, etc.)	Black, White	
93	ral', o	l by	3 ☐ Widowed 4 ☐ Divorced	tf Yes, Give Year or Dates: WWII		1□Yes 2□XNo	Specify:		Specify: W	hite
21215-0036	d within 72 hours jiene r then "neturel", ine Madical Exe	Completed by	15. Decedent's Educ (Specify only highest grade		(Give	tent's Usual Occupa	during most o	of working	16b. Kind of Business/	Industry
121	S - 22	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	irre. L	DO NOT use retired	•		Standar	rd Oil Co.
d 2	be filed with ital Hygiene. id other ther event, the N		12 yrs.			Supervis		s Name (First, Middle, M	Maiden Sumame)	
an	a ta b >	To Be	Theodore Meyers				Nel	lie Lo	chart	
Maryland	2 should and Men Is marke sumatic	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	ng Address (Street a		or Rural Route Number		Zip Code)
	12 E		Linda M. Meyers /	Daughter	1100	C Rambl	ewood	Baltimore	e, Maryland	d 21239
ore.			20a. Method of Disposition 1 Burial 2 Cremation 3 Re	20b. Plac	etery, cren	sition (Name of natory or other plac			20c. Location - City or	Town, State
Ĕ	nit. Pages artment of l ortent: if lt injury or o		*4 □ Donation 5 🕅 Other (Specify)	Entombment Be		Mem. Gard	ens Fe	b. 5, 2004	Bel Air,	Maryland
Baltimore,	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service License	* Michael E. Canap	p 22	Name and Address Leonard J		5; , Inc. Ba	305 Harford	d Road MD 21214
68			23a. Pert1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused the death, e cause on each line.	Do not ent	er the mode of dyin	g, such as ca	ardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
Ş	Physician		tmmediate Cause (Final disease or condition resulting in death)	COLON CANCER						UNKNOWN
16.	/Medical Examiner		resulting in death)	Due to (or as a consequen	nce of):					
н		70	Sequentially list conditions, b	Due to (or as a consequer	nce offi					
	nsit	min.	if any, leading to unit ediate cause. Enter Underlying Cause (Disease or injury							
Ć.	exection and inal-trained	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequen	nce of):					
68760,	death certificate be executed e attending physicien and nd for use as the burial-transit	cai	d							
68	rtifica ng ph		tF FEMALE:							
Вох	leath certifical attending phy I for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnanc 1□Live birth 2□Fetal de	eath 3	Ectopic pregnancy			23d. Date of del Month	ivery Day Year
0.	the a	sici	1 Yes 2 No	4☐Pregnant at time of deat 9☐Unknown	th 5 □	Other (specify)				,
٥	The law requires that the de ate has been signed by the a bage 2 should be detached t	Ph	Part II. Other significant conditions con	tributing to death but not resulti	ng in the ur	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ds,	sign d be	d by				, ,		1 □ Y∈	as 2□No 3□Pr	obably 4 Unknown
Ö	w requir been s should	ete						24a. Was a	n 24b. Were au	stopsy findings available
Records,	he lav e has age 2	Completed						autops perforr	ned? death?	stopsy findings available completion of cause of
Vital		a)	25. Was case referred to medical				26. Place o	1 ☐ Yes 2 1 Death (Check only on	2 No 1 ☐ Yes	2 No
≥	d in	To B	examiner?	ospitat: 1 ☐ Inpatient 2 ☐ EF	VOutpatien	it 3□ DOA Oth	or.	ing Home 5 Reside		cify)
Jοι	유부		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injun Work	at k?	28d. Describe ho	w injury occurred	
<u>i</u>	Attending or death.	atic	2 Accident investigation		. ,		Yes 2□No			
Division	I or Attandi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ural Route Number,
	urs al				165					
	To the Hospitel or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	icien: To the best of my knowle ler: On the basis of examination and manner stated.	eage, death n and/or inv	n occurred at the tin vestigation, in my of	ne, gate and pinion, death	piace, and due to the ca occurred at the time, da	ause(s) and manner as ate and place, and due	to the cause(s)
	o the	₩ W	29b. Signature, and title of certifier			29c. License	e number	2	9d. Date signed (Monti	h, Day, Year)
	- s - ō		V Kn. Ola	La KA.	20 -	n D4072	3	וים	EBRUARY 3,2	2004
	ID		30. Name and address of person who co	mpleted cause of death (ttem 2	3a) (Type,			<u> E1</u>	TOWART 3/4	200-7
	10		KARITHANOM ISAAC,M	.D., VA MARYLANI	D HEA	LTH CARE	SYSTEM	1, PERRY POI	NT,MD,21902	2
		ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatur	-	ast of				
	Regist	rar	FFR 0 4 2004	And	A. S. S. S. S. S. S. S. S. S. S. S. S. S.					

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4	020
Certificate of Death Reg. No.	025

п.	MATIUEA	S	1 - For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of Hea <i>tificate of De</i>	alth and M eath		iene 200	14 02987
	Physic		1. Decedent's Name (First, Middle, Last Ruth Ann Matthews					2. Date of Deat Month JAN		3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give JOHNS HOPKINS BAY		AL CENTER	4b. City, Town, or Lo	cation of Death		4c. County of N/A	
31	Funeral Director		5. Social Security Number 6. Se 371 64 7979	7. Age (In yrs. last birthday) 45 yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7/23/10	9 958 N	Birthplace (State or Foreign Country) Iichigan
	show	ž	Usual Residence of Decedent 10a. State 10b. County MD N/A	1	oc. City, Town or Lo Baltimore					10d. Inside City Limits 1X Yes 2 □ No
	with the M a or 28a-f	Directo	10e. Street and Number 5050 East Eager S	 t	Darelliore	10f. Zip Code 2120)5	1	0g. Citizen of Wha	
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-1 show ant, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 Ø Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No	i	Vas Decedent of Hispa f Yes, specify Cuban, I		ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc. White
15-00	n natural	Completed b	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Deced (Give life. L	lent's Usual Occupatio kind of work done duri DO NOT use retired)	n ng most of workii	ng	16b. Kind of Busin	ess/industry
Maryland 21215-0036	D d la b	To Be Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Robert Carson	College (1-4or 5+)	Ins		. Mother's Name	(First, Middle, M		ded Citizen)
	ges 1 and 2 should t of Health and Men If Item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (7) Jamie Matthews SC 20a. Method of Disposition	ON	5050	g Address (Street and East Easer	St Balt	timore M		
Baltimore,	t. Pa rtmen rtant: njury		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licens	ternoval front State	Metro Cre	,	02/02/	2004	atonsvil	le MD
ğ	Dermi Depa Impo		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused th	T	. Name and Address of 211 Chesac or the mode of dying, s	O AVELIGE	= NOSEGR	te Maryi	Approximate
) 	Physician /Medical Examiner		snock, or neart failure. List only of Immediate Cause (Final disease or condition resulting in death)		and ne	ede inju				Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c						
.O. Box 687	ath cert ttendin or use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	∃Fetal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
2	quires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions con	ntributing to death but r	ot resulting in the un	derlying cause given in	n Part I.			e to the cause of death? Probably 4 Unknown
Vital Records,		Completed						24a. Was ar autopsy perform 1X Yes 2	/ prior	a autopsy findings available to completion of cause of h? Yes 2 \(\sum \) No
<u> </u>	certifi rector	Be	25. Was case referred to medical examiner?	lospital:		Others	. Place of Death			
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	ation: To	27. Manner of Death 1 Natural 5 Pending investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2XX R/Outpatient 28b. Time of Injury 1033	28c. Injury at Work?	2	8d. Describe ho	nce 6 Other (S w injury occurred 14 Velved 1	becity) in contact h motor Whicle
	pital or Atte rurs after de eral Directo iilled in by tl	Certification:	3 Suicide 6 Could not be determined	building, etc. (stre	et	1	orth Kress	ou at Pula	r Rural Route Number, MD sky Itm Baltine
	ne Hos n 24 hc ne Fun-	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination Check only one)	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or inv	occurred at the time, o estigation, in my opinio	date and place, a on, death occurre	and due to the ca ad at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
,		Me	29b. Signature and title of certifier Zalining	49-		29c. License nu O.C.M		29	d. Date signed (M JAN . 29	onth, Day, Year) , 2004
	10		30. Name and address of person who co	impleted cause of deat	h (Item 23a) (Type, F	on Street,	Baltimo	re, Mary	land 212	01

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

		-	For State Registrar	ate of Maryland		rtment of F		•	giene Reg. No. 2001	+ 02988
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Year	3. Time of Death
-	Physici: Medic/	_	JEROME ALEXANDER M	YER	.,,			JAN. 25	, 2004	2:45 PM
	Examin	er	4a. Fecility Name (If not institution, give street	and number)		4b. City, Town, o		f Death	4c. County of Dea	ith
			CANTON FUTURE CARE 5. Social Security Number 6. Sex	7. Age (In yrs. ias	t hirthday)	BALTIN If Under 1 Year		24 Hrs. 8. Date of Birt	N/A	thplece (State or Foreign
	Funeral Director		214-03-2173		Yrs.	Months Days	Hours	Min. (Month, De	y Year) C O. 1919	MD.
	ס		Usuel Residence of Decedent							
	anylar show	_	10a. State 10b. County		Town or Lo					10d. Inside City Limits 1
	the M	Director	MD . N/A	<u> </u>	BALTIM	10f. Zip Code			10g. Citizen of What C	Λ
	with with	Ö	356 FOLCROFT STREET			Tor. Zip Code	21	224	U.S.A.	ouridy.
	ms 2:	Funeral	11 Marital Status 12. V	as Decedent Ever in U.S.	13. V	Vas Decedent of H		gin? (Specify Yes or No., Puerto Rican, etc.)		
9	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be inclined at	Fur	1 ☐ Never Married 2 ☑ Married 1	med Forces? GyYes 2∐No Yes, Give 107.3		☐ Yes 25 No	Specify:	, Puerto Alcan, etc.)	- "	
003	ural'.	d by	3 Widowed 4 Divorced Y	ear or Dates: 1945						WHITE
21215-0036	n 72 n at	Completed	15. Decedent's Education (Specify only highest grade con	pleted)	(Give	lent's Usual Occup kind of work done DO NOT use retired	during most	of working	16b. Kind of Business	vindustry
212	within jiene.	mo	Elementary/Secondary (0-12) C	oilege (1-4or 5+)	IRC	N WORKER			SHIP BU	ILDING
	be filed ital Hygi of other event, I	Be C	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Middle,	Maiden Sumame)	
<u>yla</u>	should band Ment	္	GEORGE ANTHONY MYER				ELI	LA MARTELL		
Maryland	12 sho		19a. Informant's Name/Relationship (Type, F ESTHER MYER/WIFE	rint)				r or Rural Route Numbe		
	1 and Health am 27 other tr		20a, Method of Disposition	20b. Pla	ce of Dispos	sition (Name of		BALTIMORE,	MAKYLAND 2 20c. Location - City of	
altimore,	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removed 4 ☐ Donation 5 ☐ Other (Specify)	ral from State	netery, cren	natory or other place		1/28/2004		
Ħ	그 문문을	T	21. Signature of Funeral Service Licensee	GARI				CHARLES S	BALTIMORE 2	
ä	Depa Impo sny iv		· Cleralith	Selend	20 6	224 EAST	ERN AV	VE., BALTIM	ORE, MARYLA	AND 21224
è			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death, use on each line.	Do not ente	er the mode of dyin	ig, such as	cardiac or respiratory ar	rest,	Approximate Interval Between
-	Physician		Immediate Carse (Final disease or condition	(engo	who He	Sins	Cantw-		Onset and Death
750	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):	1				*
		er	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce of):	ney of the	1			your
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Conn	Do	7. 0	J. 340.5			404.
o,	sician and burial-transit	Exa	resulting in death) Last	Due to (or as a cons = ue	nce of):		, , , , ,			1 8
8760,	2 2 2	edical	d							
9	ertifica ding pl	Med	IF FEMALE:	use suterment program						
Вох	death certifica attending ph d for use as th	ian/M	in the past 12 months?	yes, outcome of pregnand □Live birth = 2 □Fetal d □Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	Day Year
o.		Physici		Unknown		Cities (Specify)		-		
٦,	s that the ned by th e detache	by Pt	Part II. Other significent conditions contribu	ting to death but not result	ing in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
rds	law requires that as been signed t 2 should be det		Voca	nevy,	C (40	ni os	Stree	Platery 101	res 2 No 3 □ P	robabiy 4 DUnknown
Vital Records,	2 2	Completed		Dor	~ 0	AWS S	herris	24a. Was		utopsy findings available completion of cause of
E B	ate pag	Con							rifted2 death? 2XNo 1 ☐ Ye	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	al-		Oth		of Death (Check only o		
o	Phys this al dii	. To	TU Tes 2Line	1 Inpatient 2 El	VOutpatien 8b. Time of	3∐ DOA	4 × 3 ui	rsing Home 5 Resid	dence 6 Other (Spenow injury occurred	ecify)
lon	Attending I ir death. ector: Alter by the funer	tion	1 → Natural 5 → Pending 2 → Accident investigation	(Month, Day Yeer)	Injury	28c. Injur Wor M 1 [k? Yes 2⊟1		,,	
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Cuiside 6 Could not be	e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number or R	lural Route Number,
ā	ital or A	Cer		building, old. (opediny)						
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	(Check only 2 Medical Examiner:	n: To the best of my knowl On the basis of examination	edge, death n and/or inv	occurred at the tir restigation, in my o	ne, date and pinion, deat	d place, and due to the of occurred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complete	Med	29b. Signature and title of certifier	ind manner stated.		29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)
	⊢ ≯ ⊢ ŏ			24			247	76	1.57	04
			30. Name and address of person no comple	ted cause of death (Item 2	3a) (Type,	Print)			, , ,	
	JU		2501 louis	In 87		032	NO.	w	Sisser	
	Sta		31. Date filed (Month, Day, Year) FFR 0 4 2004	32. Registrar's Signatu		6.0.				
	Registr	ai	LED 0 4 500	1. W. W. W. W.	15 16					

			i icase i		Congress of Hoolth and M		
			1 _ State	-	epartment of Health and N Certificate of Death		2001. 02000
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. I	
C.E.	Physici	ian	Par Name (Prist, Windows, East)		00	Month [Day Yeer 3. Time of Death
	_/Medi		As Escilla Name (if not institution only	- 1 (SW101)	Ab Site From real position of Seath	- 10 30 3	30 2004 EA.M. M
	Examir	ner	4a. Fecility Name (If not institution, give :		4b. City, Town, or Location of Death		4c. County of Deeth
7			5. Social Security Number 6. Sec		hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTMORE
	Funeral Director		15	DM ODE I	rs. Months Days Hours Min.	(Month, Day, Yea	
4 6			Usuel Residence of Decedent	10		OCT-3 105	2 HARYLAND
	yland		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Mar Hierary	ţ	Machan Callie	iore Basi	TOORE		1 ☐ Yes 24 No
	128¢	Director	10e. Street and Number		10f. Zip Code	10g. 0	Citizen of What Country?
	death with the Maryland ims 23a or 28a-f show r.must.be notitied at		2712 Linwoo	O Avs	21234		12.CA.
	deat	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
9	after or Ite		1 Never Married 2 Married	† Yes 2 □ No		Hican, etc.)	Black, White, etc.
93	72 hours after natural', or ite	1 by	35 Widowed 4 □ Divorced	If Yes, Give Year or Dates: () :	1 ☐ Yes 25 No Specify:		Specify: WHITE
21215-0036	be filed within 72 hours after death with the Marylan Hygione. do other than "natural; or Items 23a or 28a-f show event, Itte Madical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done during most of work)	16b.	Kind of Business/Industry
21	within ene. then	Idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		CRUZ FALTER+
	ygier ygier nt, Eta	S	134BZ		SALLSMAN		LOWBANA
	d be fi	Be	17. Father's Name (First, Middle, Last)	^	18. Mother's Name	(First, Middle, Maide	en Sumame)
<u>yla</u>	Men Men Men Men Men Men Men Men Men Men	J.	15005	1 EWTON, S	R Lilli	AN 50	
Maryland	s 1 and 2 should f Health and Men frem 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty	pe, Print) 19b.	Mailing Address (Street and Number or Rura	l Route Number, City	or Town, State, Zip Code) 21234
-	and lealth im 27 her t	Н	DIANA POOLAR	39	02. ALCIECT KODO	BETTLES	OR I JARYLAND
Baltimore	90=5		20a. Method of Disposition ↑★ Burial 2 ☐ Cremation 3 ☐ R	comoton	Disposition (Name of C., crematory or other place)		Location - City or Town, State
Ë	Parity		*4 □ Donation 5 □ Other (Specify)	TARKU	OCC PRIVENT DOC		KVILLE PARTLAND
<u>3ai</u>	permit. Departmimporte my inju		21. Signal we of Funeral Service Lice se	98	22. Name and Address of Facility	12mgRiss	21234
_	70 F 4 0		Herry 4 wind		8800 HARFORD RO	PO PARK	VILLE MARYLAND
111			shock, or heart failure. List only or	cations that caused the death. Do not cause on each line.	ot enter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between
7 F	hysician		Immediate Cause (Final disease or condition resulting in death)	VENTRICULA	R FIBRILLATIO	\sim	Onset and Death
	/Medical Examiner		1950/fillig II1 deatili)	Due to (or as a consequence of			
13		_	Sequentially list conditions,	, IJCHEMIC	engionyopa	Tity	SIX YEARS
V	sit ed	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of	0:		
	executed- in and ial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of	Myoussialin	FACTI	ON IENYEARS
9	De ex icien buria	cal E			- 1610 for a Coul		
687	y S			CORONAL AI	HEROSCINONCH	VII DO	27
×	Ine law requires that the death certifica tite has been signed by the attending phy bage 2 should be detached for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnancy			
Вох	atten for u	ian	in the past 12 months?	1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
о. О.	the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	3 Citier (specify)		
ا ت	mar med by deta	, Ph	Part II. Other significant conditions con	stributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
sp.	urres n sign	d b	5N1 SIA65	RENAL ALLS	4)(2 🗖 No 3 🗆 Probably 4 🗇 Unknown
Ö	beer	ete	1	A A C C .	74.7(4	/\
Vital Records,	2 5 8	Completed by	JA32125	MELLITY		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u>a</u>	ficate		1+4 PER 18NJ	102		1 ☐ Yes 25€ N	
₹ :	rnysicien: this certifica ral director, p	Be	25. Was dase referred to medical examiner?	lospital:	26. Place of Death		DAVE HTS ES
ŏ	rhys raldi	7:	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outp 28a. Date of Injury 28b. Tir	Patient 3 DOA 4 Nursing Hon		62 Other (Specify)
uo :	After fune	ţ	1- Natural 5 ☐ Pending		me of 28c. Injury at 2 ury Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how inju	ury occurred
S	Attending ir death. ector: After by the funer	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm		8f Location (Street a	and Number or Rural Route Number,
Division of	after Dire	Certification;	4 Homicide determined	building, etc. (Specify)	in, direct, factory, direct	City or Town, Sta	re)
3	e hospital of Attending 24 hours after death. • Funeral Director: After etely filled in by the funer		29a. Certifier # Certifying Phys	sician: To the best of my knowledge.	death occurred at the time, date and place, a	nd due to the cause/s	s) and manner as stated
:	e Fu 24 h e Fu letely	edical	(Check only 2 Medical Examinations)	ner: On the basis of examination and/ and manner stated.	or investigation, in my opinion, death occurre	d at the time, date ar	nd place, and due to the cause(s)
	To tre Prospira of Attending Prystoten: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)
			Kun Nil	town	034041	Fran	VA92 ND 2004
	10		30. Name and address of person who co	mpleted cause of death (Item 23a) (T	ype, Print)		7- 200
0	* 0		TELLES N. Fo	N1AM1 560		- VI RAL	11M915 MAZIO
	Sta	te	31. Date filed (Month, Day, Year)	22. Registrar's Signature	4	1,310	7 7 01017
	Registr		FFR 0 4 2004	Honor H. A	Small a		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30 2004 Month **Physician** NANCY dEWOLF WEHR NIERMANN 01 4:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 ☐ M 2 📉 F 213-38-6681 Yrs 12/09/1927 **Director** 76 MARYLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral, or items 23a or 28a-f shore Examiner must be notified at BALTIMORE RUXTON 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6511 DARNALL ROAD 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced "natural" Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE AGENT REAL ESTATE 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or othar traumatic svent Sing. 18. Mother's Name (First, Middle, Maiden Surname) FREDERICK LEWIS WEHR NANCY THEOBALD WEHR 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM NIERMANN, M.D. 6511 DARNALL ROAD RUXTON, MD. Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State DRUID RIDGE 02/02/2004 PIKESVILLE, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipensee 22. Name and Address of FacilityHENRY W. JENKINS & SONS CO. 16924 YORK RD. MONKTON, MD 21111 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1106 lastona **Physician** MULTIFORME (0 y-ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signal 1 Yes 2 3lo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Homer (Specify) NO 7 1 ☐ Yes 2 No ၉ : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Attending Ratural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Director: A 2 Accident in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 5 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 58303 30. Mame and address of person who completed cause of ath (Item 23a) (Type, St Baltmore mp toven orles 31. Date filed (Month, Day, Year) 32. Registrar's signature State Registrar

:1300

Niermann, Dancy

Physician	. Decedent's Name (First, Middle, Last,		Cei	tificat	te of D	Peath		Reg. No.	2004	0299
/iviedical	Frances May Nizer a. Facility Name (If not institution, give			4h City	Town or l	Location of Dea	2. Date of Month Febru	ary ^D ay,	2004 County of Deat	3. Time of Death 4:30P.M
Examile	7914 Oakdale Avenu	ie		Ros	sedal	e		Ва	ltimor	е
Director	Social Security Number 219-07-9077 6. Security Number 1 Classification of Security Number 1 Classification (Number 1) 1 Classification (Number	7. Age (In yrs. 82)	Yrs.	Months	r 1 Year Days	If Under 24 Hi Hours Min	8. Date of l (Month) 05/02	71921	Co	nplace (State or Foreig unity) ryland
0	Oa. State 10b. County MD Baltimo		y, Town or Lo sedale							10d. Inside City Limits 1 ☐ Yes 2 💆 No
3a or 28 at be no	oe, Street and Number 7914 Oakdale Avenu	ie		10f. Zip	212	37		10g. Citize	en of What Co	untry?
P 2 2 2	Marital Status □ Never Married 2 □ Married 3⊠ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Dece Yes, spe		panic Origin? (, Mexican, Pue Specify:	Specify Yes or I nto Rican, etc.)		1. Race - Amer Black, White Specify:	
ed within 72 hot ygiene. Set than "natura". It is Medical E	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. L Head	kind of wo OO NOT u	ork done du se retired)	ion uring most of w	orking	Balt	imore (City
Desittimore, Maryland 21215-0035 Desimit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or my injury or other traumatic event, the Medical Examples. To Be Completed by F	7. Father's Name (First, Middle, Last) Reese Wingate	o l	ricua				ame (First, Midd re Canno	lle, Maiden S		CIII
Mary nd 2 sho aith and A 27 is ma ir trauma	9a. Informant's Name/Relationship (Ty Frances Lynn Kiebl		19b. Maitin 7914	g Address Oako	ale i	ad Number or F Avenue	Rural Route Num Rosedal	nber, City or 7 e MD 2	Town, State, Zi	ip Code)
Pages 1 and 10 feet of He and 10 feet of He and 10 feet of He and 10 feet of He and 10 feet of he and	0a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State Bal	lace of Disposementery, crem LIMOYE	sition (Nar natory or d Ceme	me of other place, etery	2/5	Date / 2004		ation - City or T imore	own, State
permit. Depart Importa	21. Sign viure of Europal Service License	8 Ott	1	Name ar 211 (nd Address Chesac	of Facility Cv co Aven	ach/Rose	edale dale M	Funeral aryland	Home 1 21237
Physician	23à. Part 1. Enter the disease, or complishock, or heart failure. List only or mmediate Cause (Final disease or condition esulting in death)		STA	+71	CL	UNG	CANC			Approximate Interval Between Onset and Death
te be exect ysician and e burial-tra	dequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury aut initiated events esulting in death) Last	Due to (or as a consequence) Due to (or as a consequence)	- CHO			NCE				
Attending Physician: The law requires that the death certifican reductions that the death certifican reduct. Attending Physician: The law requires that the death certifican better. After this certificate has been signed by the attending physy the funeral director, page 2 should be detached for use as the fifteation; To Be Completed by Physician/Medicine and the physician and the physici	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ 10 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetat 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pr Other (sp				236	d. Date of deliv	rery Day Year
w requires that the de been signed by the should be detached letted by Physic	art II. Other significant conditions cor	ntributing to death but not resu	lting in the un	derlying c	ause given	in Part I.			contribute to t	the cause of death?
to Attending Physician: The law requires the after death. Jord Director: The law requires the after death. In by the funeral director, page 2 should be a fertification; To Be Completed by								opsy formed?_	24b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
stcien: The stcien: The stcien: The stcien of the control of the c	5. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ tnpatient 2 ☐ E		•□ ••	Other		ath Check only			
or Attending Physical directions of in by the funeral directions of the control o	7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	28b. Time of Injury		8c. Injury a Work?	4 Nursing	Home 5 Thes 28d. Describe			fy)
tal or Attending P rs after death. al Director: After I led in by the funers Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory	r, office			(Street and Nown, State)	Number or Run	al Route Number,
To the Hospital or A within 24 hours after within 24 hours after completely filled in by Medical Certif	9a. Certifier 1 ☑ Certifying Phys (Check only 2 ☐ Medical Examir one)	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred a estigation,	at the time, in my opin	date and plac ion, death occ	e, and due to the urred at the time	cause(s) and pla	d manner as s ace, and due to	stated. the cause(s)
To To To To To To To To To To To To To T	9b. Signature and title of certifler	,	400	290	License r				signed (Month,	Day, Year)
JO 30	Saba Sada D. Name and address of person who co		23a) (Type, F	rint)	041	476	TOME	2	42	1
State 31	1. Date filed (Month, Day, Year)	DELPHIA 32 Registrar's Signate	Ure /<	4D		1346	ONIL	1 2	122	7

M	1 - For State Registrar	State of Maryl		irtment of		nd Ment	al Hygie	1	04	0299	
Physician	1. Decedent's Name (First, Middle, L					М	ete of Death onth	Day 30, 2	Yeer	3. Time of Death 4:32 P	
/Medical Examiner	ELAINE 4a. Fecility Name (If not institution, g 4214 BAYONE AVE	•	NS	4b. City, Town	or Location of	f Death	INOAKI	4c. County		4:32 P	
Funeral Director	5. Social Security Number 6. 217-58-9821 Usual Residence of Decedent	Sex 7. Age (In) 1 ☐ M 2 X F	yrs. last birthday) 50 Yrs.	If Under 1 Year Months Day		Min /A	ate of Birth fonth, Day, Ye 29, 1	953	9. Birthp Cour	place (State or Fore htry) DC	
Nore, Maryland 21215-0036 1ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it leave 7 ie marked other than "natural", or items 23a or 28a-1 ehow or other traumatic event, the Medical Examiner mant by multiple at To Be Completed by Funeral Director	10a. State 10b. County	NA 10c.	City, Town or Lo	TIMORE 10f. Zip Code	21206		10g.	Citizen of V	What Cour		
21215-0036 ed within 72 hours after death vygiene. yogiene. ver than "natural", or flems 23a it, the Medical Examinant controlled.	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest of	If Yes, Give Year or Dates:	16a, Deced	Vas Decedent of Yes, specify Cu Yes, specify Cu Yes 2X N ent's Usual Occ	f Hispanic Origuban, Mexican, lo Specify:			Dia	AFRI AFRI AMEI	CAN RICAN	
Maryland 21215-0036 and 2 should be filled within 72 hours alt fulls and Mental Hygiene. 27 le marked other than "natural", or rtraumatic event, the Medical Exact To Be Completed by F	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last	College (1-4or 5+) 1 st)	iite. L	kind of work don DO NOT use reti CLERIC	AL	's Name (Firs	t, Middle, Mai	den Suman	INIST	JRITY FRATION	
e, Maryla 1 and 2 should 4ealth and Men 7 ne marke ther traumatic.		S (MOTHER)	123_V	g Address (Stre		r or Aural Aou	te Number, Ci BALT IMO	RE, M	D 21	218	
Baltimore, permit. Pages 1 at Department of Hea Important: if item eny injury or other	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) VOSHELL CEMETERY 2/6/04 BALTIMORI 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WYLIE FUNERAL HOME								RE. N	E MD	
by Special Examiner Special Examiner Examiner Special Exa	Immediate Cause (Final disease or condition resulting in death) 5-aquantially set conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hypertensic Due to (or as a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Due to (or a condition Du	sequence of):	ioscler	otic Ca	rdiova	scular	Disea	ose	Onset and Death	
vision of Vital Records, P.O. Box 68760, Attending Physicien: The law requires that the death certificate be executed death. setor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transitification: To Be Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 💢 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death 3 [Ectopic pregnar Other (specify)	ncy			23d. Dai Mo	e of delive	ory Day Year	
cords, P w requires that been signed t should be det	Part II. Other significant conditions	contributing to death but not	resulting in the ur	derlying cause o	given in Part I.	2		2 🗆 No	3 🗆 Prob	ably 4 AUNKno	
Vital Record ition: The law requir certificate has been s rector, page 2 should						1	4a. Was an autopsy performed ☐ Yes 200	24b. \ 1? No 1	Vere autoprior to conteath?	psy findings availant pletion of cause	
Division of Vital Records, To the Hospital or Attending Physicien: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a Medical Certification; To Be Completed by	25. Was case referred to medical examiner? YETYPES 2 No 27. Manner of Death THAT Autural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year	2 EP/Outpatien 28b. Time of Injury	28c. Inj	other: 4 ☐ Nur					SCENE	
Division c To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not 4 Homicide determine	building, etc. (Sp	ecify)			C	ity or Town, S	fafe)		l Route Number,	
the Hospi thin 24 hou the Funer mpletely fill	(Check only ane) Medical Ext	Physician: To the best of my aminer: On the basis of exam and manner stated.		estigation, in my	opinion, death		he time, date	and place, a	and due to	the cause(s)	
To To Cor	29b. Signature and title of certifier 30. Name and address of person wh	o completed cause of death ((Item 23a) (Type, I	0	C M E			Date signed			
State	LING LI. 31. Date filed (Month, Day, Year) FER 0.4.200	M ₁) 2. Registrar's Si			Penn St	reet, I	Baltimo	ore, M	laryl	and 21201	

			1 - For State Registrar	State of Maryland		ent of H		Mental Hygien	/ U1114	02993
Н	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month D	ay Year	3. Time of Death
3	/Medi		DOMINIC A.	PETRO				JANUARY Z	8th 2004	6:25 AM
	Examir	ner	4a. Fecility Name (If not institution, give		4b. (City, Town, or	Location of Dea	ath 4	c. County of Death	n #
	F1		5. Social Security Number 6. Sec	enter 7. Age (In yrs. last	birthday) If U	nder 1 Year	If Under 24 Hi	S. 8 Date of Birth	a Birth	Colone (State or Foreign
516	Funeral Director		189-03-8212 1	M 2□F 87	Yrs. Mon		Hours Mi		16 Pen	nplace (State or Foreign untry) 1 SY Wania
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location					10d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show frital be notified at	ctor	Maryland Baltin	nore Co. Gle	en Arr	n				1 ☐ Yes 2 No
	with th	Funeral Director	12005 Manor R	and	10f	. Zip Code	57		Chi Si	- A
	death ms 2	nera		12. Was Decedent Ever in U.S.	13. Was D			Specify Yes or No-	14. Race - Amer	ican Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show may injury or other traumatic event, its Medical Evaritmer must be notified at DDGs.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 □No If Yes, Give Year or Dates:		specify Cubai s 2/2 No	Specify:	orto Rican, etc.)	Black, White	hite
2-0	72 ho	ted	15. Decedent's Edu (Specify only highest grade	cation 16	6a. Decedent's I		tion uring most of w	16b. I	Kind of Business/la	ndustry
21215-0036	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	Tuse retired)	1 -		Beth. S	iteel
	filed whygie ther ther ther ther ther ther there	ပိ	17. Father's Name (First, Middle, Last)	14	Ca			ame (First, Middle, Maide	7 7 7 7	,, 1
/lan	uld be Mentai rrked o	To Be	Dominic Pet	ro			Elea		chini	
Maryland	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship (Ty, Maria R	De, Print) (Daughte) 1	9b. Mailing Add.	ress (Street a	nd Number or F	Bural Route Number, City Glen Hor	or Town, State, Zi	ip Code)
-	s 1 and f Healt item 2 other		20a. Method of Disposition	20b. Place	of Disposition	Name of	T		ocation - City or T	
Ē	Pages nent of int: If it		1, 2 urial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State	tery, crematory	eatem	Jan	1,31,2004 1	3altimo	re, MD.
Baltimore,	permit. Departm Departm Importar any inju		21. Signature of Funeral Service License	gair Se.	23. Name	efu	of Facility	tives Fine	ral + Ci	emation Cent
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	calions that caused the death. D	o not enter the	mode of dying	, such as cardia	ac or respiratory arrest,	of poil.	Approximate Interval Between
2	Physician		Immediate Cause (Final disease or condition	CORONAKY						Onset and Death
	/Medical Examiner		resulting in death)	Due lo (or as a consequenc	e of):	7				S I GAIGA .
100		Jer	Sequentially list conditions, if any, leading to immediate	. Due to (or as a consequence	ce of):					
	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
8760,	cate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a consequence	e of):					
687	physicate by the control of the cont	dical	d					-00		
ŏ	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy					23d. Date of deliv	arv.
о. Щ	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopi 5 □ Other	c pregnancy (specify)			Month	Day Year
<u>Ч</u>	uires that the de: signed by the a id be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions con		in the underlyin	on cause diver	in Part I	23e Did tohacco	use contribute to 1	the cause of death?
Records,	w requires been signs should be	ed by			y and andony	ig daddo givoi	THIT GITT.			bably 4 Unknown
9 0 0	ne law re has bee	Completed						24a. Was an	24b. Were auto	opsy findings available ompletion of cause of
m =	ysician: The Is certificete hadirector, page	Com						autopsy performed?	death?	
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	osnital:				ath Check only one		
of	5 5 7	<u>۲</u>	1 Yes 2 No		Outpatient 3		4 Nursing	Home 5 Residence		(y)
O		tlon	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	. Time of Injury M	28c. Injury : Work?	es 2 □ No	28d. Describe how inju	ry occurred	
Division of Vital	Hospitel or Attending F 44 hours after death. Funerel Director: After tell filled in by the funerel	Certification:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At home, building, etc. (Specify)	farm, streel, fac			28f. Location (Street ar City or Town, State	nd Number or Rura	al Route Number,
	pitel o		29a. Certifier 1 Certifying Phys	1						
	To the Hospitel within 24 hours a To the Funerel (completely filled	Medical	(Check only one)	ician: To the best of my knowled er: On the basis of examination a and manner stated.	ge, death occurr and/or investigat	ed at the time ion, in my opi	, date and plac nion, death occ	e, and due to the cause(s urred at the time, date and	and manner as s place, and due to	tated. the cause(s)
2	To the within 2 To the comple	ž	29b. Signature and title of certifier	A		29c. License	number	29d. Da	te signed (Month,	Day, Year)
17			Sensa m.	Currely ms		051	1739	JAN	VARY 28	3th 2004
	4		30. Name and address of person who con	1		1?		ſ		
	Sta	te	31. Date filed (Month, Day, Year)	32. Fegistrar's Signature	1 59	Ima	re M	paryland	21215	·
	Registr	ar	EER 0 4 200	4 Property H.	Breek	9				

DHMH 17 Rev 1/2001

Registrar

Carrie of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1- State
Registrer AMENDITEM #23a-c& PII&24a PER PHY Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Year 10:23 M PUSKARICH JOHN DANIEL 01 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HAUREDE HAZFOND MEMOMAL HOSPITAL LACE FOND HAR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2 F Yrs. Director 219-60-5455 Italy Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "netural", or flems 23e or 28e-f show treumatic event, the Madical Examinar must be notified at 1 Tyes 28 No marvland Harford Aberdeen Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 642 Andrews Road 21001 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes > NO þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fir f Health and Mental H item 27 is marked ott Joseph Marion Puskarich, Sr. Asta (unk) Ritson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ritment of Health a 642 Andrews Road, Aberdeen, Maryland 21001 Ladda Puskarich / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gardens 2-2-04 Importent: I any injury o once. Aberdeen, Maryland A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Hell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line ACUTE CHOLESCYSTITIS with CRANGENE Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) CHOLFLITHIASIS and OBSTRUCTION of COMMON BILE DUCT- DISTAL Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ned by the attending physician and detached for use as the burial-transit SEPTICEMIA secondary to GRAM NEGATIVE BACTERIA Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? A PLEURAL EFFUSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 爲Unknown DIVERTICULOSIS ASCENDING COLON 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 XXY es 2 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No Certification: To 1 🗓 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred After 5 Pending 1 MNatural death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be To the Hospitel or Attervithin 24 hours after de To the Funerel Directo completely filled in by the 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) A--unish M-D 21809 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRABHO TIMONIUM MOZIV93 MD 2336

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 4 2004

32. Registrar's Signature

9214

ooksi

ND

			1 - For State Registrar	State of Maryland	l / Depa <i>Cen</i>	rtment of He	ealth and M Death	ental Hygie	Com (-)	02996
			1. Decedent's Name (First, Middle, Last)	1.	0					3. Time of Death
	Physici		GENEVA	DANCY	FU.	TNOR		Honth JANUAN	Day Ye	
	/Medi Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or I	ocation of Death	ľ	4c. County of D	
			To Church Poin	A Rel		NOLT	HEAST		600	7/
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)		If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		Birthplace (State or Foreign
	Director		305-28-9029 10	M 20F	Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ar)	Country) INDIANA
	D .		Usual Residence of Decedent					7	<i>// · · · · · · · · · · · · · · · · · · </i>	71071
	how How		10a. State 10b. County		Town or Loc					10d. Inside City Limits
	Ma Ma	Ş	Md Cecil	/	Vont	h EA	ST			1 ☑Yes 2 ☐ No
	n the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What	Country?
	h wil		20 Church P	out Rel		2	1901		U.S.	Ac
	deal deal	Funeral		2. Was Decedent Ever in U.S Armed Forces?	. 13. W	as Decedent of His Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-		merican Indian,
9	after or its		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ② 100		/		Rican, etc.)		/hite, etc.
පු	ral',	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	11	□Yes 2⊡No	Specify:		Specify: C	Shite
20	be filed within 72 hours after death with the Maryland ital Hygiene. did other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Evantinal control for indiffic	Completed	15. Decedent's Educ (Specify only highest grade	ation (completed)	16a. Decede	nt's Usual Occupat	ion	16b	. Kind of Busine	ess/Industry
2	thin 8	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. Di	O NOT use retired)			. /	
2	er th	Son	12			House w	, Fe	/	Home us	Her
p	A THE THE PER	Be (17. Father's Name (First, Middle, Last)	1		1	8. Mother's Name	(First, Middle, Maid	ten Sumame)	
<u>la</u>	Went Went riked	To I	WALLACE EgI	laster DAVIS			Gene	UA NA	104 D	4015
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The mortant: If lear 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Evernment intellibet at once.		19a. Informant's Name/Relationship	e, Print)				Route Number, Cit		
Σ	and alth		MALSINAII PUI	Crel	20 C	horel F	Sind Rom	1. North.	EASTIN	021901
ē	of He Item oth		20a. Method of Disposition	20b. Pla	ce of Disposi	tion (Name of story or other place)	Da		Location - City	
Ë	Page ent c nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)					1/2004 0	Do to	1 121)
=	artm ortal	1	21. Signature of Funeral Service License	0	22.	Name and Address	of Facility	7/2009	CE COVIE	N P (I)
B	Deparenti Importanti eny ir		A DOR				0	1. 7/1/	1,00	110 - 100 203
The			23a. Parti Enter the disease, or complic	sations that caused the death					very by	Approximate
			shock or heart failure. List only on Immediate Cause (Final	e cause on each line.	- 1	and mode of dying,	Socii as cardiac oi	Abspiratory arrost,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Deme	hiti	2				
67	Examiner			Due to (or as a conseque	nce of):					
		_	Sequentially list conditions, if any, leading to immediate	Due to describe						
	sit ed	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nge utji					
	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	can	that initiated events resulting in death) Last	Due to /or an a consequent						
8760,	cian cian ourial	Ē		Due to (or as a conseque	nce or):					
87	ate t shysion the b	dlcal	d.							-
9	ing p	Me	IF FEMALE:							
Вох	eath certifi attending p	an/	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of pregnand 1☐Live birth 2☐Fetal d		ctopic pregnancy			23d. Date of	,
O.	be dec	sici	1 □ Yes 2. □ No	4☐Pregnant at time of dea 9☐Unknown		Other (specify)			Month	Day Year
<u>Ч</u>	that the de led by the a detached t	Phy	9 Unknown							
Ś	res tha igned be del	by Physician/Me	Part II. Other significant conditions cont	ributing to death but not result	ing in the und	erlying cause given	in Part I.	23e. Did tobacc	o use contribute	to the cause of death?
פֿ	w requir been si should I	ed	WE LOSS -	•				1 🗆 Yes	2 12 № 3 1	Probably 4 Unknown
သို့	aw r	Completed						24a. Was an	24b. Were	autopsy findings available
œ ,	The lav	E						autopsy performed	death	
ta	detificate certificate rector, pag	0	25. Was case referred to medical				6. Place of Death	Chack and and	46 1□Y	es 2 No
5	Physician: rthis certifica ral director, j	0 8	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ EF	3/Outnatient	3□ DOA Other:		_	6 🗆 Other (C	
Division of Vital Records,	g Phys er this eral di	님	27. Manner of Death		8b. Time of	28c. Injury a Work?		d. Describe how in		рөспу)
0	th.	9	1 ☑Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Year)	Injury		s 2□No		,	
18	dea dea ctor	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	e, farm, stree	t. factory, office	28	8f. Location (Street	and Number or	Rural Route Number,
á.	after Dire	ert	4 ☐ Homicide determined	building, etc. (Specify)				City or Town, Sta	ite)	
	spite ours neral fille		29a. Certifier 1 Certifying Physi	cien: To the best of my knowle	edne death o	courred at the time	date and place as	ad due to the enues	(a) and ======	
:	24 h 24 h Fui etely	Medical	(Check only 2 Medical Examination)	er: On the basis of examination and manner stated.	n and/or inve	stigation, in my opin	ion, death occurred	d at the time, date a	nd place, and d	ue to the cause(s)
,	To the Hospitel or Attending Phywithin 24 hours after death. To the Funeral Director. After the completely filled in by the funeral	Me	29b. Signature and title of certifier			29c. License n	number	294 [Date signed (Mo	onth Day Year)
, '	- > ⊢ ŏ				NA F	10001	102	06	A) () () () () () () () () () (
	V.	-		nexu	109	J D 0070	100	14	- しめ-2	1004
	り		30. Name and address of person who com	pleted cause prodeath (Item 2	За) (Туре, Pr	(1) land 1 =	ract 1	101-10:	N AI	140
			31. Date filed (Month, Day, Year)	. Registrar's Signatur	w	wrth	M X	nuryllu	111 -11	101
	Sta Registr		EED 0 4 2004	A. nogistial S Signatur	ANDRE	20		F.		

			1 - For State Registrar	State of Marylai		nent of He cate of D			iene g. No. 200	4 02997
>	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last, Aa. Facility Name (If not institution, give 5. Social Security Number 6. Sec	street and number) HEEZ R 7. Age (In yrs	O.A D last birthday) If U	Be I.A	ocation of Death	2. Date of Deat Month ANUAR 8. Date of Birth (Month, Day,	Day Yea 930 200 4c. County of De	ord
	Director	or	Usuel Residence of Decedent 10a. State 10b. County	10c. C	Yrs. Mon		Hours Min.	April 4	Year) 1937	irinhplace (State or Foreign Country) 10d. Inside City Limits 1 ☑ Yes 2 ☐ No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "neturs!, or items 23s or 28s-1 show may highly or other treumatic event, tre Mexical Exertinest be notified at ance.	by Funeral Director	10e. Street and Number 10	12. Was Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0 10f 0.S. 13. Was D If Yes,	. /	oanic Origin? (Sp Mexican, Puerto Specify:		Og. Citizen of What of the Company o	Country?
d 21215-0036	filed within 72 hou Hygiene. other than "neturs ent, I.e Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	cation e completed) College (1-4or 5+)		f work done dur Tuse retired) VUFA	CTURI	ing	16b. Kind of Busines ENGINE Aaiden Sumame)	
Maryland	12 should be h and Mental if is marked o	To Be	John HAW 19a. Informant's Name/Relationship (Ty		. 170	ress (Street and	d Number or Rura	al Route Number,	City or Town, State	
Baltimore, N	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar tr once.		20a. Method of Disposition 1 Burial 2 Defenation 3 R 4 Donation 5 Other (Specify) 21. Signa in of Funeral Service License	emoval from State	Place of Disposition cometery, crematory	(Name of or other place)	February February	Date 2	Oderton	or Town, State M.J.
*	Physician /Medical Examiner		23a. Part Senter the disease, or complishood or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	al Carci	My (1) mode of dying, s	such as cardiac o	or respiratory arre	UNELLY D.K. 14	Approximate Interval Between Onset and Death
,0928	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, any, leading to mine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec						
P.O. Box 68	that the death certifics led by the attending ph detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 Live birth 2 Fete 4 Pregnant at time of continuous Unknown	el death 3 Ectopi	ic pregnancy (specify)			23d. Date of do Month	Blivery Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Dther significant conditions con	tributing to death but not res	sulting in the underlying	ng cause given i	in Part I.	23e. Did toba		to the cause of death? Probably 4 □Unknown
Vital Rec	sician: The law certificate has E rector, page 2 s	e Completed	25. Was case referred to medical			20	6. Place of Death	24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	autopsy findings available completion of cause of
Division of V	g Phys terthis neral di	Certification: To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	DOA Other: 28c. Injury at Work?	4 Nursing Hor		nce 6 Other (Sp	ecify)
Divis	= = = =		3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifician: To the best of my known of the state o	y) owledge death occur	red at the time	date and place	City or Town,	isa si and manner a	s stated
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical	(Check only one) 2 Medical Examir one) 29b. Signature and title of certifier	er: On the basis of examina and manner stated.	ition and/or investigat	tion, in my opini	on, death occurre	ed at the time, dat	le and place, and du	e to the cause(s)
	5 \$ 5 8		30. Name and address of person who co	moleted cause of death /Hoo		29c. License ni	90		d. Date signed (Mon $2-2-6$	24
	Sta	-	Michael Mc (o) 11	mpleted cause of death (Iten	105 Fronkl	in Sque	ne Dr.	Bultimor	e mo	21237
	Registr	ar	FEB 0 4 2004	The said of	A STATE OF THE PARTY OF THE PAR					

			r	State of Marylan				-	ene	
			1 - For State Registrar	,,		tificate of L		-	2004	02998
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medi		Ruby Eliz	abeth	Rac	lford		Month January	30, 2004	9:20 p ^M
já –	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death	,	4c. County of Death	
			Regency Park Assi	sted Living		Gambrill	s		Anne Aru	ndel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(eer) 9. Birth	place (State or Foreign untry)
	Director		233-74-7196 Usual Residence of Decedent	ZHA: 09	Yrs.			Feb. 18,	1914 Vir	ginia
	land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Man P-f eh	tor	MD Anne Aru	ndel (Gambri1	.1s				1 ☐ Yes 🎎XNo
	or 28;	Director	10e. Street and Number			10f. Zip Code		100	J. Citizen of What Cou	untry?
	23a	la C	963 Arundel Lane			21054			USA	
	tems	Funeral		12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1	-	I∐Yes 2∑No	Specify:		Specify:	White
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow ther, Itan Medical Examinar must be notified at	edk	15. Decedent's Educ		16a Deced	lent's Usual Occupa	tion	16	b. Kind of Business/I	
715	nin 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	kind of work done di DO NOT use retired)	uring most of work	ing	b. Raid of businessal	idostry
2	giene giene er tha	Completed	12	College (1940) 34)	Homen	aker			Own Home	
9	al Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
yla	Men Men arke	2	Charles William H					Brickey		
Mar	12 sh h and 7 ts m raum		19a. Informant's Name/Relationship (Ty)						City or Town, State, Zi	p Code)
	1 and Healt em 2	0	James Radford (So			rundel La		· · · · · · · · · · · · · · · · · · ·	 21054 Location - City or T 	oum State
no	Pages nent of I snt: If it		1 Burial 2 ☐ Cremation 3 ☐ R	allioval Ilolli State		sition (Name of natory or other place			•	
Baltimore,	그 본 변 중 .		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22	Mem. Park Name and Address	of Facility	17 11	Salem Virg	ınıa
ä	Depa Impo any ii		my			Hardesty	Funeral :	Home, P.A	is, MD 21	401
	* *		23a Part1. Enter the disea le, or complie shock or heart fail re. List only on	cations that caused the deat	n. Do not ente	er the mode of dying	, such as cardiac o	or respiratory arrest	, PID 21.	Approximate Interval Between
	Physician	1	Immediate Cause (Fin 1)	ENO-TO						Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence		20000	67 677			6 million
В	Examiner		Sequentially list conditions, b							
	bed issit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a consequ	uence ut):					
	be executed icien and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence	uence of):		7			
760,	o S o	caiE	d							
89	leath certificat attending phy i for use as the			0V-12-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-						
Box	th cer endin r use	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Fetai		Ectopic pregnancy			23d. Date of deliv	ery
Э. Е	e dea he att	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of do		Other (specify)			Month	Day Year
P.O.	that the de led by the a detached f	Physician/Med	9 ☐ Unknown Part II. Other significant conditions continuous	tribution to double but not you	deine in the con-	4-4-1		District		
Records,	Se Dig	t by		whe Cold					co use contribute to t	pably 4 (4Unknown
Ö	w require been sign	etec			6 24/6-	1en	Herice			
Re	ne lav s has ge 2 :	Completed	- Hyperten.	Tec of				24a. Was an autopsy performed	prior to co	ppsy findings available impletion of cause of
Vital		e Co	25. Was case referred to medical				00 Bl (B	1□ Yes 2€		2 No
	Physician: The this certificate his ral director, page	O B	examiner?	ospital:	ER/Outpatient		26. Place of Death		e 6 TOther (Sacci	y) Assiskelling
יסר	문 는 B	T:u	27. Manne Death 1 V atural 5 Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury a Work?	at 2	28d. Describe how		11/201114 2007
Ö	Attending it death. ector: After by the fune	atlc	2 Accident investigation	(, 23, 133.)	пцогу		es 2□No			
Division	I or Attendate after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Rura itate)	al Route Number,
	pital ours a eral D		29a. Certifier 1FT Certifying Physi							
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in by	Medical	(Check only one)	ician: To the best of my known: On the basis of examinat and manner stated.	wiedge, death ion and/or inv	occurred at the time estigation, in my opir	, date and place, a nion, death occurre	and due to the caus and at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	ro the	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month,	Day, Year)
j		1) ne	MO.		05.	5506		02/02	104
	10		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, F	Print)				
	`		Fer Eren MD	8/09 Rife	hie,	Highwa	1 Par	dene	1704/0	nd 21/22
Q.	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 4	npleted cause of death (Item 32. Registrar's Signar 2004	ture	freels.				
	negistr	:U	LED A T	and the same of th	6	A STATE OF THE STA				

VOID

CERTIFICATE

04-0299

SEE

CERTIFICATE #

04-03938

1 - State Registrar AMEND ITEM #5 PER FH G828 2/18/04 Chertificate of Death 1. Decedent's Name (First, Middle, Last) Physician Medical Examiner 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	
/Medical Examiner A. Fecility Name (If not institution, give street and number) 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	
Examiner 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	
	4c. County of Deeth
231 GLANDS GLAY	Cecil
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date	of Birth 9-23-19319. Birthplace (State or Foreign Country)
Director 216-28-0527 12M 20F 72 Yrs. Months Days Hours Min. Month	33, 131 MRY GAUD
Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Ma a Ceal ELKTON	1 ☐ Yes 2 ☑ No
The state of the s	10g. Citizen of What Country?
1 231 WOODS WAY 21921	U.S.A.
10a. State 10b. County 10c. City, Town or Location Column	or No- 14. Race - American Indian, Bleck, White, etc.
1 □ Never Married 2 ☑ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify:	Specify: / / ~ /
3 Widowed 4 Divorced Year or Dates: 1950-1953	White
TOD County 10a. State 10b. County 10c. City, Town or Location County	16b. Kind of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+)	Electric
N pole : O	
E SEPA M	FERBEL
The state of the s	
a a a collision of the	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State	1 2
La de la la la la la la la la la la la la la	ay Ochenter Md
20a. Method of Disposition 1 Burial 2 © Cremation 3 Removal from State 1 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility	1. 1011
Juanta & Thomas MNATOMY OF PTS REGISTY	526 Counely Ph HAVOLOR MAION
23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock or heart failure. List only one cause on each line.	ory arrest, Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition disease or condition as the condition	5,00, 4,10 5,00,1
/Medical resulting in death) Due to (or as a consequence of):	
Sequentially list conditions. b.	
O 13 m, leading to minediate Due to jor as a consequence on:	
De to (or as a consequence of):	
Ogo and of the control of the contro	
Hither age of the state of the	
The part of the pa	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
O = 5 g g g g g g g g g g g g g g g g g g	
The state of the s	Did tobacco use contribute to the cause of death?
v 8 58 a	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
s bode and a second a second and a second and a second and a second and a second an	
24a.	Was an autopsy autopsy findings available prior to completion of cause of
Com The Page has a set has	performed2 death? es 2 No 1 Yes 2 No
1 Y Y Y Y Y Y Y Y Y	nly one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	Residence 6 Other (Specify)
27. Manne of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?	ribe how injury occurred
VO Service 1 1 Natural 2 Accident 2 Accident 2 Accident 2 Accident 3 Siciode 4 Deposited 4 Deposited 4 Deposited 4 Deposited 1 Natural 2 Sevential 1 Natural 2 Natural	
DIVIDIA PROPERTY OF STATE OF S	on (Street and Number or Rural Route Number, r Town, State)
Cei i i i i i i i i i i i i i i i i i i	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one)	
e q e g q e	29d. Date signed (Month, Day, Year)
29b. Signature and title of certifier 29c. License number	2 3 200 -
	21312009
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	21207
21 Date filed (Month Day York) A Pagistrade Signature	
State 31. Date filed (Month, Day, Year) Registrar FER 0 4 2004	